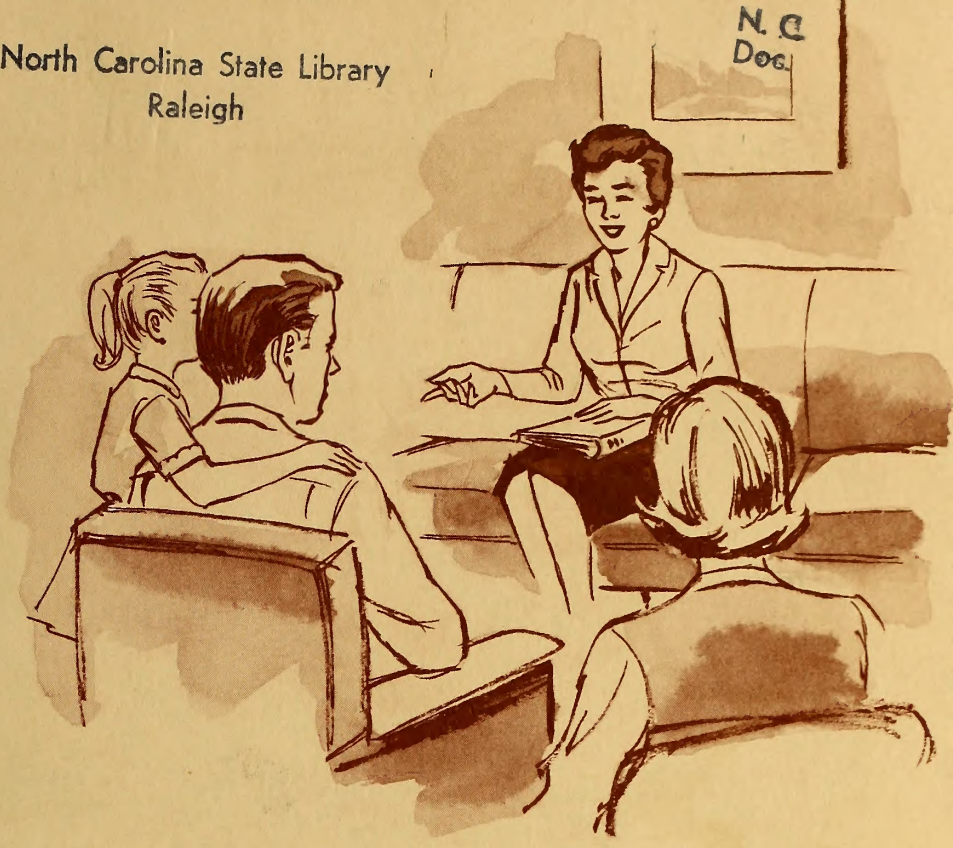

Manual on ALCOHOLISM

for Social Workers

Manual on Alcoholism for Social Workers

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PREFACE

This manual replaces a section of the ALCOHOLISM INFORMATION KIT FOR SOCIAL WORKERS which was used for many years in the educational endeavors of the North Carolina Alcoholic Rehabilitation Program whose work is now continuing in the Education Division, North Carolina Department of Mental Health. The kit consisted of general information on alcoholics and alcoholism in pamphlet form and a series of mimeographed articles selected specifically for their usefulness to social workers. It was widely used by the experienced (in alcoholism) as well as the inexperienced social worker in varied settings, including family service and mental health facilities, alcoholism programs, welfare departments and students.

This manual is **not** intended to stand alone. It replaces only that section of the kit which was selected specifically for its usefulness to social workers —the mimeographed articles—and has been carefully added to, and subtracted from. The serious student or practicing social worker will supplement its use with selections from the wealth of general and specific information on alcoholics and alcoholism that is available.

It **is** hoped and **intended** that this manual will find greater utility in its printed form and that its influence will thereby be extended. In addition to being more attractive than a stack of mimeographed articles, the manual is designed for easy readability and storage. It will rest easy between bookends on a desk or in a desk drawer where, with a bend of the back (forward or down), a stretch of the arm and a firm grasp of the hand, it will be available for ready reference. Treasured ideas which come to the reader as he reads can be jotted down on its wide margins or on the "note" pages which are scattered throughout the manual. Our point—that it may truly be a **working** manual—is clear, we hope.

It is our belief that wherever there is a practicing social worker in whatever setting, there is also an opportunity to help an alcoholic or his family. Social workers are being utilized in settings previously closed to this profession, for example, the Domestic Relations Court in Charlotte, N. C., and are increasing in others, for instance, the North Carolina Prison Department. We wish to reach them all.

This manual was planned and prepared in consultation with Roberta E. Lytle, A.C.S.W., psychiatric social work consultant, N. C. Alcoholic Rehabilitation Center, and George H. Adams, communications consultant, Education Division, N. C. Department of Mental Health, and, of course—last but not least—the contributors of the articles.

Lillian Pike

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FOREWORD

The problems resulting from alcoholism are not new to social workers, who have been dealing with them in their case loads since the days of Mary Richmond. The reluctance, then, with which today's social workers approach treatment of the alcoholic himself is convincing evidence of the helpless feeling which too frequently assails them at the thought of extending him casework service—a feeling, let it be said, based on disappointing experience in this area of human suffering. Social workers, along with clergymen and physicians, understandably feel challenged by the alcoholic and have responded with an attitude not unmixed with defensiveness. Nevertheless, I believe their sincere desire is to extend their understanding and professional concern to these physically, psychologically, socially and spiritually ill human beings who now are considered the number four health problem in the nation.

It is paradoxical that, in our century, noted for the spirit of inquiry and achievement in the health sciences, it was a lay group which opened the door to a fresh concept of the alcoholic and his ability, with help, to recover from his illness. Fortunately through their acquaintance with the Alcoholics Anonymous movement, implications for the professional treatment of the alcoholic were recognized by three dedicated and able men. Impelled by their deep concern, as well as their interest in research, Dr. Ralph Banay and Dr. Georgio Lolli, in close collaboration with E. M. Jellinek, established in 1944 the first two outpatient psychiatric clinics, devoted exclusively to the treatment of alcoholics. Known as the Yale Plan Clinics, one in Hartford, the other in New Haven, Connecticut, they blazed the way for the phenomenal spread of education, treatment and research which now prevails in the United States and Canada. The fruits of their early labors can be seen in the forty-some alcoholism programs set up under state and provincial governments in the United States and Canada; in the many summer schools on alcoholism, chief among them the Rutgers Summer School of Alcohol Studies, formerly centered at Yale University; in the early establishment of the Quarterly Journal of Studies on Alcohol; in outstanding centers for research on alcoholism, such as the Alcoholism and Drug Addiction Research Foundation of Ontario. From the beginning, social workers responded to the challenge of this new approach and pioneered along with other members of the psychiatric team, in this exciting and uncharted venture.

Although publications, both professional and semi-professional, developed in the wake of the Quarterly Journal, social work articles were few and far between. Those of us working exclusively in the field of alcoholism watched hungrily for the writings of our colleagues and seized on opportunities to meet with each other in order to share experiences and information. Through the good offices of the National Institute of Mental Health and the North American Association of Alcoholism Programs, we were afforded opportunities to meet both regionally and nationally, where formal papers were presented, and the beginnings of a social work literature on alcoholism were established. Much of the credit for this boost to social work morale must be attributed to Dr. George Stevenson, then on the staff of the National Institute of Mental Health. Some of those early papers, notably by Jean Sapir, and Anne Wenneis Webb have been included in this presentation.

While most of the papers in this collection have been written by social workers, two have been contributed by physicians, whose special knowledge and experience, we felt, would serve to round out and amplify this compilation. We wish to thank all our friends who gave so generously of their time and skills to this manual, and trust it will creditably fulfill its mission.

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NOTES

Social Workers *Can Help* Alcoholics

BY R. MARGARET CORK, M.S.W.

Problem Drinking has been with us far longer than the profession of social work. Throughout many ages other professional groups, notably the medical and the clergy, have struggled with little general success to find a way of helping those involved in problem drinking. With the beginning of professional social work many social workers added their efforts to those of the other helping professions but with the same sense of failure to both patient and therapist.

Then Alcoholics Anonymous came along about twenty years ago, followed by the work of the Yale University School of Alcohol Studies. From these we have gained a body of knowledge and understanding which has enabled thousands heretofore neglected, rejected or overlooked to become rehabilitated or, in medical terms, to find not cure but recovery.

Here in our own community medicine slowly began to apply these new tools and skills; industry became acutely concerned; reform institutions started programs of rehabilitation; and education has shown interest in prevention.

What of social workers? Have we as a profession concerned ourselves sufficiently about a problem which is in great part a social one, which plays a major part in the breakdown of family life and is in turn caused in great part by upset, disturbed or negative relationships within the family? I do not believe we have, either to the extent that other service professions have, or to the extent that is necessary if we believe that this illness is not to be treated purely as a physical one but as one in which the person is also emotionally, spiritually and socially ill.

"Social Workers Can Help Alcoholics" was published in *Inventory*, Volume 6, Number 4, 1956 by permission from *Canadian Welfare* magazine. Its author, R. Margaret Cork, M.S.W., is chief psychiatric social worker of the Alcoholism and Drug Addiction Research Foundation of Ontario. Its use in this manual is by permission of the author.

Since the Ontario Alcoholism Research Foundation came into being social workers appear to have lagged behind the other service professions in making use of the knowledge, skills and treatment offered. During the past year only three social workers used the Foundation on a consultative basis, and out of a total of 576 patients referred only 22 were referred by social agencies.

Obviously this challenge is not meant to imply that individual social workers are not actively concerned, nor is it meant to imply that the problem is to be solved by social workers alone, or that all the 49,000 alcoholics in our province should be referred to one small treatment team at Brookside Clinic. It does imply that social workers should join in a team with other service professions to give that part of treatment which

can only be given by social workers, and work with others in a way never used before to achieve the goal that Dr. Gordon Bell feels is possible, namely, almost complete eradication of this illness "which everyone hates but few understand."

This then brings us to the subject matter of this paper, which is to define problem drinking for social workers and to show what it means in their work.

Who is the Problem Drinker?

Who then is the problem drinker? How can we distinguish him from other people who drink? Are we as confused in our identification as many in the community who label anyone who gets drunk an alcoholic? The social worker must be able to differentiate, for purposes of treatment as well as interpretation in the community, between those who drink at all and those who are alcoholics.

For our purposes the alcoholic may be described as a person whose drinking in any continuing or regular way is upsetting the stability of his life or his home; he may be described as the person who is unable to have a satisfying life without the use of alcohol; the person who is unable to face the demands or responsibilities of life without an increasing dependency on alcohol; as the person who is basically insecure and unhappy, seeking to relieve the pain of living through the use of alcohol.

Feelings About Alcoholism

Today as a result of numerous articles most people are paying lip service to the belief that the alcoholic is a sick person. It is one thing to be able to accept this fact intellectually, however, but quite another matter to accept it emotionally. With this is closely mingled or interwoven our inability to be as objective about this as we are about other social ills. There seems to be a relationship between our attitude now and our lack of concern or our inability to give constructive help in the past.

There does not seem to be any clear cut reason for this but perhaps there are a few factors worthy of consideration, any one or all of which may be responsible: our cultural, historical or individual conditioning to the use of alcohol or to drunkenness; our preconceived, and still active, ideas of its being a moral problem or one which demands a moral judgment of the sick person, such as historically we gave to relief recipients or consumptives; our conflict about the place of alcohol in our culture or our individual lives; our fears, conscious or unconscious, about the relatedness of *any* drinking to alcoholism, our very lack of knowledge and experience of an illness so different from all other illnesses.

Characteristics of the Illness

At this point I should like first to consider this last factor, namely, how this illness differs from others. It differs from others in that, except for the acute stages, the person is up and about; he has no well-defined pain or diseased area; he is often successfully carrying on with a job that calls for skill and training; he is sometimes managing to carry responsibility in the home.

In this illness, in contrast to others, both the ill person and the community resist recognizing it.

It is an illness that brings feelings of shame to the family and causes them to resent, ridicule or ignore the suffering person; that causes feelings of guilt, remorse and self-condemnation in the sick person himself. It is an illness that increases the sick person's feeling of inadequacy, depletes his slight store of self-confidence and adds new fears to those that were in part responsible for his initial dependency on alcohol.

Where do we see another illness in which there are so many relapes or acute stages? An illness which makes a person lie, steal, cheat, hurt those closest to him, or throw away all that seems to be of value to other people? Where do we find another illness in which the ill person has to give up the only thing that has seemed to offer him release from pain and security in life in order to get well? It is an illness that affects the total person more than any other illness, and yet in which the sufferer more strongly resists or denies the need for help and tends to believe, or tries desperately to believe, that he can cure himself.

Alcoholism is a complex illness that has many hidden aspects, and only one readily recognizable aspect—the regular or periodic drinking bouts—an aspect which looms so large, creates so many problems in and of itself that it is small wonder that families, the public, and often those who are trying to help the alcoholic, see alcohol as the one cause of alcoholism and never get far beyond this.

The patient is considered ill only when he is severely intoxicated and the tendency is, between bouts, to act toward and expect behavior from him that we would expect from a well person. The very fact that his behavior between bouts so often has a pseudo-wellness to it fools us again and again into believing that he is cap-

able of responding normally to the demands and pressures of society and his family and those who may be trying to help him.

What is the Alcoholic Like?

Behind the pseudo-wellness, the rather likeable, interesting personality, the abilities and relative degree of success on the job, the above-normal or average intelligence, who do we see? We see, more often than not, a very dependent person who has come into adulthood ill-prepared by his earlier experiences in life to cope with adult experiences; a person who finds it hard to relate to others, who has few inner resources, interests or hobbies, who is easily upset, hurt or frustrated, and who acts out his impulses; a person who has little self-confidence, who is overly concerned about what people think of him and who has fears real and imagined about his place in life and other people's affections—in short, a person who is emotionally immature and insecure.

How Do We Help Him?

So much for our understanding of the sick person. How can we help this person? Above all we must respect him as an individual worthy of help, no matter what condition he appears in. (Florence Hollis has said "One has to like people very much and be convinced of their essential dignity and worth as human beings in order to get past the dirty and unlovely exteriors of some clients").

We must meet his request for help quickly, with warmth and readiness to give help; we must be able to let him know quickly that we like him and understand his desperation and his mixed feelings about coming to us for help; let him know that we understand his conflicts about treatment or about giving up the one thing that has given him comfort and release from tension; we must recognize the fears he brings, fears of having to give up his independence, fears of being further rejected, condemned, or fears of what is going to be done to him.

As with the disturbed child we may need, in the initial stages, to give words to these fears and feelings, so that he knows that we know how he is feeling before he gives in to the impulse to run away. If his need to leave or withdraw is great because of coming to us under too great pressure or because he still is unable to face giving up alcohol, we must be able to help him leave with just as real a sense of our interest in him as though he were going on, and with some real awareness of the ways in which we can help him when he is ready to come back.

Often this recognition of his right to make his own decision, along with the warmth of his reception, is the turning point in his thinking about himself and his problem, and even though he may not come back for a month, or even a year, he more often than not does come back.

Lastly, we must be aware that often the problems that he presents first may be very threatening social or emotional problems incurred as a result of his drinking. Only when these have been met and he has some tangible evidence of our desire to help him can he move on to consideration of his real or basic problem.

Here then are some of the necessary factors involved in helping the ill person to begin to use help, either ours or that of someone else to whom we may refer him. What is involved in the continuing contact?

First of all we must recognize that the contact is likely to be a long, supportive one, involving endless patience and countless interviews which may have to be maintained whether we refer him to a clinic, a physician, a clergyman or to Alcoholics Anonymous.

Just as in a clinic setting where the patient needs, and is encouraged, to form relationships with a variety of people (in spite of the fact that one particular person may be responsible for his formal treatment) so in the community he needs several different sources of support. We must slowly be able to help him to move out to and make use of these other sources. Unless we know them well and believe in their ability to help him, whether it be clinic, physician or clergyman, we cannot truly help him lose his fears or make the best use of such contacts.

A continuing relationship with an alcoholic presents unique difficulties and hazards, elsewhere encountered in some respects only in work with emotionally disturbed children. (In no sense, however, does this mean he should be treated as a child or that the relationship can be the same as that with such a child). We must, however, understand and expect that the alcoholic will come to his experience with the social worker full of mistrust and fears, and with a constant need to test out our interest in him.

This means, therefore, that we must not only move out to meet him more than half-way but we must be prepared to sustain a warm, less formal, more flexible relationship than is normal to other professional relationships.

The relationship must be one in which he can

readily see and feel our love and respect for him no matter what his behavior; which can accept his broken appointments, the broken promises, the distortions of truth, the relapses, the swings of mood and the overt hostility toward us when we don't or cannot do as he wants us to; which imposes few limits and which allows him to see us, when possible, whenever he needs to.

Slowly, very slowly, within a relationship such as he has not likely experienced before, he may become able to proceed from the known to the unknown; he may not only gain a new understanding of his illness but become able to control it, he may begin to regain, or find for the first time, a sense of his own worth; he may begin to face reality, to solve some of his social and emotional problems; he may, in short, begin to gain satisfactions and joys from a way of life that is not dependent on alcohol.

Indirect Help

No definition of this problem would be complete without a word about the indirect help that can and should be given. This may be done (with the patient's consent) through interpretation to employers or others in the community. More often it is with the wife and family of the sick person. This is not just a matter of interpreting the ill person or his behavior; in fact very often such a method, if used first, only brings greater resentment and greater resistance to changing the attitudes which, though they do not cause the alcoholism, play a very real part in relapses or continued drinking.

We must bring to the wife some of the same understanding of *her own* problems as we do those of her husband, recognizing that wives of our patients very often have great needs of their own, which may in part have led to their marrying a sick person in the first place but which certainly have increased and been exaggerated through years of living with him.

We know, for instance, that she more than likely brought to the marriage great dependency and affectional needs, as well as a good deal of conflict about sex. (Incidentally withholding of the sexual relationship is the most often used, as well as the most often carried-out, threat used by wives towards their sick husbands. We can readily see how this affects the sick person as well as the total marital relationship). She came to marriage with her own needs only to find that she was denied the satisfaction of them because her husband's needs were too great.

A wife's own emotional dissatisfaction, the demands to meet his needs, the unpredictability and shame of this behavior, the constantly recurring social problems and the growing disturbance of the children, have left her physically and emotionally depleted.

As we see her she is full of mixed feelings, fears and attitudes, and reluctant to give up the adjustment she has made to her situation, by which she has become dominating, nagging, threatening, punitive or indifferent. In some instances she has subtly encouraged his drinking because of her own needs or fears. Sometimes she demands or almost dares those helping her husband to succeed where she has failed and at other times begs us to work a miracle.

Sometimes, too, she is desperate for help but has as many resistances to using it as the sick persons has himself. There is little positive value in trying to gain her cooperation in the patient's treatment until she feels our genuine interest in her as a person separate from her husband, and sees tangible evidence of our ability and readiness to help her with her own very real problems.

In the initial stages a wife may only ask for, or use, specific direction as to what she should do in such matters as taking a drink with her husband, pouring the liquor down the sink, protecting him from the results of his drinking, feeling ashamed of him, or reasoning with him when he is intoxicated (to all of which the advice is "don't"). She may at first only use her relationship with us to get rid of her extreme anxiety and hostility. However, as she feels the worker's acceptance she will be able to begin to work more positively on the total problem.

When a trusting relationship has been established, help should be given not only toward gaining knowledge of the illness and its formal treatment, but also toward her own attitude about drinking, about the illness and the man she cares for.

The help should have as its goal not just rehabilitation of the sick person but also a lessening of her conflicts, anxieties, tensions and frustrations, so that she can lead a more satisfying life with or without her husband's recovery, more adequately meet the children's emotional needs so that they will be as little damaged as possible by the fact of having a father who has the illness, alcoholism; can make a decision to separate or stay with her husband, not in anger or desperation, but having worked through her feelings on the matter with someone who brought to it a measure of objectivity.

Most wives, it has been found, do not really

want to leave their husbands even though they threaten to do so or appeal to us for help in doing so. When she first comes for help a wife is usually just as divided in her feelings about leaving her husband as the patient is about giving up his alcohol.

If, however, she is determined to do so, our acceptance of her decision, and a thoughtful appraisal of what is involved in separation, may often help her to face realistically the implications of a life on her own; may help her to recognize her true feelings in regard to her husband as well as her desire to try, with help, to find the way to a more satisfying, or at least a more tolerable, life together.

The most difficult things for a wife to accept emotionally are the fact that her husband's behavior is the result of an illness rather than a lack of affection for her; the fact that his sobriety alone will not likely end all her problems or bring the satisfactions they are both seeking in their marriage; the fact that the children have been as much, if not more, affected by the difficult parental relationships and their mother's hostility toward their father, as by his excessive drinking. As she becomes more sure in her relationship to the worker and the tension in the home relaxes she may look for indirect help with the children and the problems they are presenting.

At times, the adolescent children may have become so emotionally upset that they also need direct help to gain an understanding of the illness and their own feelings about it. Often a mother tries sincerely to give the children an interpretation of the illness, and tries to help the children see their father as an ill person, but her own hostility and ridicule of him when he is drinking leave them more in conflict than ever. Only as a mother or the children, or both, are helped to find emotional stability can we hope to prevent their becoming the emotionally ill or possibly alcoholics themselves.

Women Alcoholics

What of the women who are themselves suffering from this illness? So far I have talked about men, for the most part, because so far as we know only one in six of those suffering is a woman. Our experience and knowledge is gained primarily by working with men. However, most of what I have said would apply to women who have this illness, with a few possible exceptions.

One exception is that the illness appears worse in a woman patient, and it is more difficult with the knowledge we have today, to rehabilitate her. Why this is so has not been scientifically shown but it seems to be related to such factors as her ability to hide her drinking longer and thus become more ill before she seeks treatment.

Another exception is that there is additional guilt and shame about her drunkenness because of her place in society as a woman and a mother. Another is that she may have difficulties in having a satisfying relationship with a member of the opposite sex. And lastly (in contrast to most women, who stick to their ill husbands), the majority of men who are married to women alcoholics seem to leave their ill wives or, if they do not leave them, seem much less able to seek or use help in understanding the illness or the ill person.

Attitudes of Social Workers

This definition of problem drinking and its meaning to social workers would be incomplete without a look at our own attitudes which were mentioned earlier. How do we really feel about people suffering from this illness, and are we able to recognize we still may have feelings that are affecting our ability to help them?

Do we so hate, and are we so repulsed by, the effects of the illness that we can't help transferring our feelings to the person who is ill?

Do we, even with our own intellectual knowledge and outward acceptance of this illness, have so much feeling about the use of alcohol in any way that, under the guise of helping the ill person, we react unconsciously, as does society, in a punitive, authoritarian or moralizing way? These are questions which each of us can answer for ourselves, but positive help for the person suffering from alcoholism depends in great part on our answers to them.

To sum up, the problem may be defined according to our knowledge and understanding of the illness, of the ill person, and of treatment methods; of our best casework skills given with a warmth and reaching-out beyond what is called for in other relationships; of our freedom from basic prejudices, misconceptions, fears and moral judgments, as well as from any personal problems relating to the use of alcohol.

Last, but not least, it is defined in terms of a personal faith in the redeemability of every human being, so that we ourselves may not give in to the feeling of hopelessness so often engendered by society, so that the person suffering this illness may be enabled to find through our recognition of spiritual values the way to his own, without which he will never be completely well.

The Nature of the Helping Process

BY ALAN KEITH-LUCAS, Ph.D.

To help another human being may sound like a very simple process. Actually, it is one of the hardest things that anyone can be called on to do.

We all know our failures in the field. We know the person who refuses to be helped—the client who won't get medical care, the fellow who won't take the job we offer him even though it would seem that to do so was the most obvious common sense. We know also the man who accepts our help but uses it in a way that troubles us or seems self-defeating—the public assistance recipient who uses his grant to become more dependent instead of less so, the man who seems to accept our advice but somehow manages to pervert it so that it does him more harm than good. And we know perhaps only too well the person who uses our help as long as we are there to watch over him or "jack him up" but backslides as soon as our back is turned.

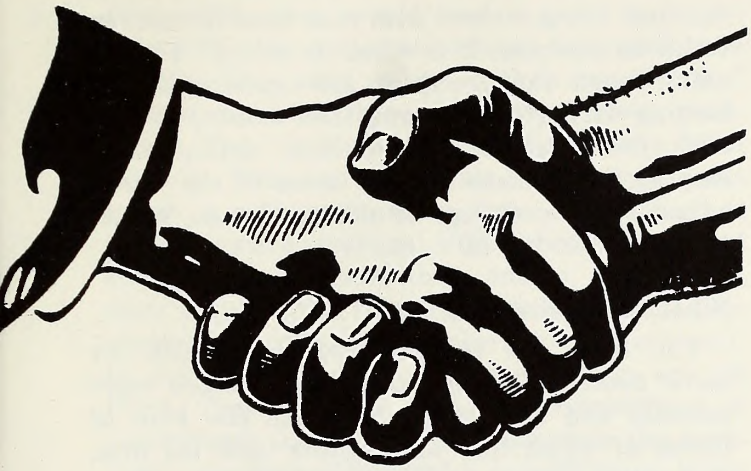
Our natural reaction is to blame the people who do this to us, or to attribute their failure to get and to use help to some inadequacy in them. We label them as immature or sinful or uncooperative or stubborn or just plain "no'count."

What do we do then, once we recognize this wrongness? We can do any number of things, and from the Early Church Fathers to the heyday of the Poor Law and even into the era of modern scientific methods of helping, we, and society as a whole, have done one or all of them.

We have sometimes refused to help those who refused to help themselves, or who have used our help unwisely. We have washed our hands of them. Or we have tried to force them to do something about themselves by punishing them in some way, through starvation, or shame, or the workhouse, by the whip or the stocks, or by what is known as less-eligibility—forcing them to live at a level below what health and decency demand. Or again, if we are very patient and full of a desire to help, we have tried one of three methods according to our knowledge and taste. Sometimes we have gone on trying to help in the same way, believing that in the end the water will wear away the stone. We have exhorted and urged and persuaded and bombarded with good advice. Sometime we have hoped that if only they could learn to like and admire us, some change might be forthcoming, and we have been extra nice and nonjudgmental and friendly.

I am not saying that people have not been helped in perhaps all of these ways. But I do suggest that all of those answers fail to take into account one very important fact about the helping process which is perhaps the key to helping on a deeper level. And this is simply the fact that helping is a two-way process, involving two people, and that what goes wrong in the helping may lie to no small extent with the person who offers help or with the process through which help is being extended.

To give help really means to *offer someone an*



"The Nature of the Helping Process" is a chapter in the book, *The Church Children's Home in a Changing World.* It is published in this manual by permission of the author and publisher, the University of North Carolina Press which holds the copyright. The author, Dr. Alan Keith-Lucas, is an Alumni Professor, School of Social Work of the University of North Carolina.

opportunity to change. All other help is simply a patching up until the next breakdown, necessary perhaps for the moment but of no lasting significance. This was recognized by such pioneers as the Christian Socialists and the Charity Organization leaders of the last century when they fought to replace casual charity with planned concern for those in need. But those sincere people made one very great mistake. They thought that what went wrong with the helping that they saw all around them lay in *what* was given and not in *how* it was given. They thought that money or material things did not offer a framework in which change could take place and that intangible things such as advice, persuasion and friendly interest did. This is a mistake still made by many modern helpers, who exalt "services" such as counseling and ignore the help that can come from something as prosaic as a public assistance grant or transportation somewhere or a job or a little time to rest.

What these people do not see is that all help is potentially good if the recipient can choose to make use of it and that no help is good if the recipient doesn't. So that helping comes to mean *something tangible or intangible, offered in such a way that the person to whom it is offered can choose to use it—that is, choose to change* through its use.

But we do have to be very careful about this word "choose," for we use it in a rather special sense. To choose to use help means much more than to select a course of action or even to make up one's mind to do something. It means the decision of the whole person to go along with something, to do something about something, to risk oneself and everything one has in order to get something better.

This kind of choosing does not mean that the person being helped is free to do anything he wants without suffering the natural or legal consequences. It has nothing to do with freedom of choice in the usual sense. One cannot make it because one ought to or sees good reason for doing so or because someone else wants one to. For this kind of choice is terribly hard. It is terribly personal. And it is terribly dangerous. Truly, as in a wider context, one must lose one's life to gain it and to ask someone to change is to ask one knows not what.

For making this kind of choice always means at least four things. It means admitting your own failure. It means putting oneself more or less in the power of another, letting him know you and take a part in your life. It means hard work, for the choice has to be made again and again in different contexts, although the fact of having once made it makes it more possible the second and the hundredth time. It means risking the unknown; giving up a present certainty, even though this may be an uncomfortable one, for a good which cannot as yet be fully seen.

And there it might be said that the correspondences between the process of asking for human help and the religious experience of conversion are so remarkable that they cannot, I feel, be entirely accidental. The words repentance, submission, steadfastness under temptation, and faith, are plainly corollary to the four elements that have been described here—a fact that is perhaps hard to realize until one has experienced both.

I do not suggest that this is exactly the same process. In fact, there is one very important difference. The person approaching God for help must try to submit entirely to His will. What individuality he maintains is then God's gift. He

must also intend his submission to God's will to be permanent. The person seeking human help cannot submit to the will of the helper. If he does so he defeats his ends. In fact, he must always maintain his integrity as a separate person, against the will of the helper. This is, I would suggest, because the helper's will is of the same imperfect nature as his own and because human will tends always to control and not to set free. And again, the helped person makes this submission not forever, or even wholly for a time, but for a specific purpose and for a limited length of time. Nevertheless, he must admit the helper to some extent into his life.

If this is what being helped means, is it then surprising that people will do almost anything to prevent themselves from experiencing it? Is it surprising that many of them refuse to admit their real need? Is it surprising that others demand help of us on their own terms—"give me my check and leave me alone"—as a means of warding off any demand really to change? One of the safest ways of not encountering God is to go to church every Sunday, sing all the hymns, and obey all the rules. Often enough the person who says that he wants help, who does what seems all he can do to get it and yet finds it beyond his grasp, is in reality refusing it.

Let me try to illustrate this with a case. Here, for instance, is a longshoreman with a hernia that can be repaired so he can do light work.

A vocational rehabilitation counselor helps him get it repaired and finds him a job as a clerk. The client is cooperative. He keeps appointments. He tries to learn what he needs for his new job. He takes a position offered to him. But in a month or two he develops a psychosomatic asthma and has to go to bed again.

He wasn't a malingerer. The asthma was very real. He didn't sit down and figure out: If I get asthma I won't have to work. But in the recesses of his mind he was full of fears. He was afraid of his new job—could he succeed at it? He feared having once more to compete in a world of well men that would make no excuse for him, for he was no longer ill. And maybe he feared, too, what this new job meant to him. He was no longer the masculine figure tossing bales. He was pushing a pen—an old man's job that could be done by a girl. And so his mind and his body together threw up a protection for him. If he were sick, he was safe from his fears. And this, we are beginning to understand, is the real meaning of much of the sickness, both mental and physical, that we see in this world. More and more diseases are shown to be protections against pressures one cannot stand.

This is a state which, in my profession's peculiar jargon, we call ambivalence—wanting two contradictory things, feeling two ways at once. It is a paralyzing condition, so paralyzing, in fact, that it often looks like laziness, lack of moral stamina, being content with poor conditions, even feeble-mindedness. It is what "is wrong" with so many people that we think are inadequate. And helping very often becomes then *making it possible for people to resolve their ambivalance;* helping them choose (in our sense of the word) to get well, to change or not to change, to use help or not to use it.

What the Choice Must Be

For there are certain conditions which we know make the resolution of ambivalence more possible and free people to make the kind of choice of which they are capable. And the first, and perhaps the basic one on which all the others depend, is in itself a paradox. It is that a positive choice is only possible where the opposite choice is also possible and acceptable. Intellectually this may not be too hard to see. Man cannot choose to be good unless he can also choose to be bad. If God had compelled man to be good, he would not be good at all. Again, man cannot choose to live fully unless he can also choose (or accept) death. Nothing is gained without risk, and to say "Yes" sincerely always means that I could have said "No."

But this truth is terribly hard to recognize in practice. We so much want the man we are helping to make the right decision, to choose independence and not dependence, God and not the Devil. Even to recognize the possibility that he may choose the wrong seems like treason to us.

When we try to *make* someone into something that he has not chosen to be, it is utterly defeating. Man must always be free to do—even to "curse God and die." And we, and even our cherished values, are not, of course, God. What we think of as the wrong choice may for another person be right. Even if it cannot be, the choice must still be there. The risk must be taken. And the person who makes the wrong choice is much closer to help than he who makes no choice at all.

That is why I insisted that help must be help to choose to be well or to choose not to be well. All we can do as helping people is to set up those conditions that free a man to make this choice. And thus we come to the second condition, which is a corollary of the first: *The choice must be*

made by the person helped. It cannot be made, it cannot even be too passionately wished, by the helper. For the helper to put his own will into it takes it away from the will of the helped; for the helper to persuade or cajole increases rather than resolves the helped person's ambivalence.

And this is why it is usually true, as a third proposition, *that people need a great deal more help with their negative feelings than with their positive.* They need to look at their negative feelings, to examine them, to discover their weaknesses. Their positive feelings usually get a lot of support. They are acceptable and everyone can weigh in with reassurance, hope or praise. It is their negative feelings with which they must struggle—their fears, their doubts, their hates, their despair. And this cannot be done, some psychologists and some preachers to the contrary, by pretending that the negative feelings are not there. They are. The man who exhorted us to "accentuate the positive and eliminate the negative" may have discovered a rule of social intercourse, but he never had to help people in real trouble—which is why the extroverted, Pollyanna kind of helper who always wants to keep things pleasant is sometimes more harmful than helpful.

It follows therefore, fourthly, that the *helping relationship* must be one in which negative *feelings can be expressed without fear of blame, anger, sorrow, or loss of face.* This means in turn that it cannot be a relationship of superior and inferior, saint and sinner, wise and foolish, judge and judged, or even their modern equivalent, adjusted and unadjusted.

The Helped and Helper Are Equals

As helped and helper struggle together to understand, to come to a point where the helped person makes his decision, they must struggle as equals, either of whom could have felt and thought like the other.

It must deal with real things, however unpleasant. A doctor who refused to consider cancer of the anus because either he was afraid of cancer or he preferred to ignore the bathroom would be no doctor at all. So help with social problems must deal with what is really there—with real sorrow, real hate, real sin, and real despair. It cannot deal with false reassurance, with polite evasions, with "pie in the sky."

It must be based on trust, on the belief that man can be helped, however wayward he may seem.

And finally, and proceeding from this, *it must be based on humility* (in the Christian sense of the word). And this is because in the end you don't know what is right for another (you are lucky, indeed, if you know it for *yourself*); you don't have to face what he is facing (and pray God you never may have to); you don't and you never will, know the length and the breadth and the depth of a man. Thus I end this list, as I began it, with a paradox. The more you know, the less you know.

These conditions for helping are what prompt me to ask from any would-be-helping person three very impertinent questions which are nevertheless very pertinent:

Do *you really want to help?* Do you want to put yourself truly at the service of another, which is not everybody's desire? Or do you in your heart of hearts want to be thanked or to control or to ease your own conscience or to serve some other end? If you do, I do not blame you. There is much else you can do, but helping is not your forte.

Are you tough enough to help? Any idea that helping is a "sissy" business is very far from the truth. It can be and is something that calls for every reserve of courage anyone can muster. It takes toughness to face reality, to risk anger, to strip the polite veils from sorrow, to endure doubts and despair. It takes courage not to disarm them by glossing things over, by being self-righteous, by keeping things on a pleasant and utterly meaningless level.

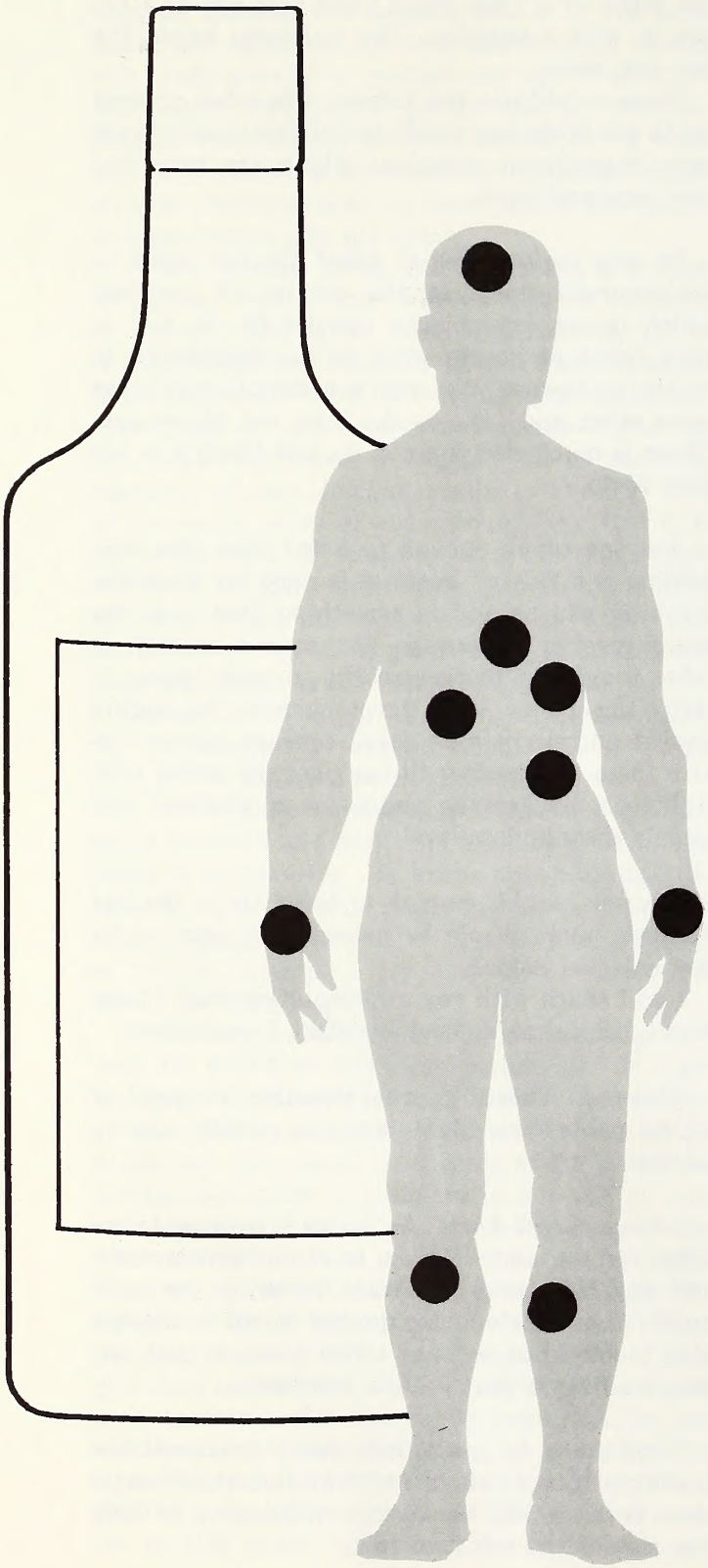
Are you humble enough to help? Or in the last analysis must people be helped your way or by you and you alone?

I will share with you a formulation that I have found helpful as a check on what I am doing.

This is it. This is the real situation, stripped of all its polite coverings—what you really are up against:

I know that it hurts. As far as it is given to me I feel *for* you and *with* you in facing this trouble, and any time that you want to bring out your anger, your fear or your doubts it will be acceptable to me—not because I feel them myself but because I know that I *could* feel them.

I will stand by you to help you if you want me. I will not force you in any way but at the same time nothing will shake my willingness to help you should you ask it of me.



ALCOHOL

It's Physiologic and
Effects on the Indiv
and
Treatment of Alcoh

BY NORMAN A. DESROSIERS, M.D.

It is of particular importance to the social worker to be cognizant of some of the more important pharmacologic effects of alcohol upon the psychologic performance of the alcoholic or problem drinker who comes for counseling or other types of help. Such knowledge can materially assist one in his management of any given case, and in the action taken at certain junctures in the relationship between the social worker and the alcoholic. A brief experience related by a certain clergyman will serve to illustrate the necessity of having such information.

This particular clergyman told about a certain parishioner who, when under the influence, would visit him about every two hours all night long declaring that he had a sermon to preach, and that he wanted to preach it on the morrow. Of course, this was always on a Saturday night, a matter of constant chagrin and exhaustion to the unfortunate clergyman who, not wishing to offend the good brother, always allowed him entrance and audience. The clergyman did admit that after a year or so of such behavior, he wondered why on earth one visit per Saturday night was not enough, and why the inebriated brother said exactly the

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The author, Norman A. Desrosiers, M.D., is medical director of the N. C. Alcoholic Rehabilitation Center at Butner, N. C., an in-residence treatment facility for alcoholics. He wrote this article on request especially for this manual.

same thing over and over again. Moreover, he was also aware of the fact that whatever he told the inebriate never seemed to register. His words didn't seem to get across, as if the man could not learn. The number of hours this particular clergyman spent in counseling this inebriate was really phenomenal—but wasted! When he discovered, as a result of the training session he was in, that in fact the cognitive functions of memory and the associated learning process were seriously impaired by the presence of alcohol in the brain, he was more than chagrined. He literally moaned with grief over the countless hours of sleep he had lost in working with this individual. He learned the hard way, what every psychiatrist learns early, that one does not attempt counseling or psychotherapy with anyone under the influence of alcohol. The cognitive functions have to be fully functioning for tnat exercise, and they are not fully functioning under the influence of alcohol. Needless to say, the knowledge of this particular effect of alcohol upon the brain can save one a considerable amount of time.

The Anesthetic Effect of Alcohol. It must be remembered that the use of ethyl alcohol is in reality the self-prescription of an orally ingested anesthetic. As ordinarily ingested, in small amounts over a period of time, the level of anesthesia reached can vary from the slight giddiness and euphoria of a few drinks to profound depression and even death by respiratory paralysis after excessive amounts. An understanding of its effects upon the individual however are best understood as the process of anesthesia.

One should understand that the process of anesthesia is one of gradual depression of the nervous system from the very beginning of any drinking episode. A disturbing fact, however, is the oftnoted feeling of lift, or increased energy the user experiences, which is quite contrary to what he's been told about the depressant effects of alcohol. If he is not hungry, tired and tense before supper, he knows that a few drinks makes him feel like he has more energy, is less tired, and has more of an appetite. All of these effects, he notes appear to be stimulatory, and beneficial to him in his worn-out, anorexic state. Try to tell him that he is in reality under the influence of an anesthestic agent and that his brain function is depressed, and of course, he will laugh at you. He appears to be stimulated, his mood is euphoric, *not* depressed, and you say his brain function is depressed. Surely you must be mistaken.

But one is not mistaken. His brain function is depressed, and what one sees and what he feels clinically belie what is in reality going on in his physiology. In order to understand what is happening during the early phase of intoxication an analogy must be employed to explain apparent stimulation as a result of actual physical depression of nervous function.

The nervous system can be thought of as a carefully balanced scale whose normal operational range is quite narrow. Whenever one upsets the balance by adding or subtracting forces on one side of the scale, the reaction of the scale will be quite the opposite and equal reaction to the disturbance. During the early stages of intoxication (anesthesia) the balance of opposing forces in the brain is upset by the depression of the most susceptible portion of the brain, and the apparent stimulation seen clinically is the compensatory uncontrolled release of other portions of the brain from their normal control. What

appears then to be stimulation is in actuality depression with abnormal release of higher nerve centers. Clinically and experientially the net result of early intoxication, or more properly early anesthesia, is the well-known delusional feeling of well being or euphoria. It is nevertheless, the beginning of the process of anesthesia, a phase of the process known as the early excitement phase. It is during this phase and subsequent phases of central nervous system depression that the tremendously important psychological changes that the user experiences occur.

The Psychological Effects of Alcohol

In order to have some grasp of the profound depth of dependence that many persons develop upon alcohol, one must come to understand the importance of what alcohol does *for* the user. One of the common approaches used during early group sessions at the Center is to ask the simple question, "What does alcohol do *for* you?" The reactions are immediate and interesting. There are always a few who anticipate that one is asking about the bad effects and reply with answers about the deleterious effects that alcohol has on their lives. But we don't buy this defensive maneuver, the tide of discussion soon turns, and the emphasis is always on the physical and psychological blessings that the use of alcohol brings. By far and away, the most important thing to understand about the effects of alcohol upon man is to have a grasp of the tremendous psychological value that it has for the user. And the corollary statement must again be re-iterated, that all of the psychologic changes that occur under its influence are the direct result of the effect of alcohol on functioning brain tissue.

An illustration from an actual case example will serve to clarify this point. During such a session where the virtues of alcohol were being vicariously relived, one very debilitated little fellow who had been drinking for some 50 years, summed up the discussion beautifully when he observed, "Why Doc, I haven't found anything it isn't *good* for." And in a very concrete sense he was right. It can be used for anything. For the layman, it is his best self-prescribed patent medicine, or panacea. It can be used to relieve just about everything psychologically uncomfortable, even milder physical pain. In fact, the fellow in the illustration chose to die with it one month later, rather than to give it up. It will be a useful exercise, then, to consider some of the more important psychologic changes that alcohol produces in order to grasp more fully the real meaning of alcohol to the user.

Psychologic Effects: The Key Word - Forget. Probably the key word that underlies a great deal of abnormal drinking behavior is the word *forget.* One hears in group after group such statements as, "It helps me *forget* my worries," or "It helps me *forget* my work," etc. One of the outstanding qualities of alcohol is that it can and does affect the memory process, especially for recent events, so that the user is relieved of the pressure of disturbing events, memories or conflictual feelings of recent origin. Any readily available substance that will do this for an individual everytime without fail, even for a temporary period of time, must be taken with due respect. This fact of experience, namely alcohol's ability to erase recent memory and even remote memory depending on the amounts ingested, should begin to give one a better understanding of the inebriates behavior, and of the addictive potential of this substance.

Further clinical observations of inebriated behavior substantiates this point. Have you ever wondered why it is that the individual intoxicated with alcohol is heard to repeat himself again and again and why it is that no matter how many times one attempts to get something across to him, it fails to sink in and to be retained? The explanation again is found in the fact that the cognitive functions are disturbed, namely memory and the associated learning function; so much so that he cannot in fact remember what he may have just spoken or heard, and so he repeats himself or makes the speaker repeat himself.

There are all degrees of impairment of these cognitive functions depending, of course, upon such factors as age, native intellectual capacity, degree of organic deterioration, as well as the degree of intoxication; however, the disturbance is there, temporarily chemically induced, and is an easily discernible clinical condition.

There is a very important corollary to this observation; namely, to ask oneself, while counseling with an alcoholic, if he has the smell of alcohol about him, or if one notes constant repetition of the same statements, just "What am I attempting to do here?" "Just how effective can I be in counseling with a person who is basically incapacitated in his ability to remember what is said to him, or even to remember what he has said himself?" The awareness on the part of the psychiatrist of the disturbed cognitive functions of even a mildly intoxicated individual accounts for his doing no more than to give the individual the protection, and physical support that he needs

until he reaches a completely sober state, after an appropriate period of convalescence. A lack of awareness of this particular facet of the inebriates mental condition under the influence of alcohol, both in the acute state as well as into the convalescent stage of any acute episode, has resulted in a lot of wasted time on the part of outpatient staffs in particular. One cannot do psychological therapy of any sort on a person whose brain function is temporarily rather seriously impaired. Other than to do very simple supportive type counseling with an inebriated or convalescing alcoholic is unwise and wasteful of one's time. Moreover, to do more than to give only short periods of one's time to an individual in such a state is to play right into his neurotic needs—unfillable over dependency—and to unconsciously encourage the perpetuation of such a state. An understanding, then, of the particular effect of ethyl alcohol on the cognitive function of memory in the pathologic drinker is important to the social work counselor. Such knowledge can save him valuable time in many instances, and also enable him to avoid un-therapeutic relationships with this particular type of client.

The Psycho-physiologic Effect of Alcohol: The Blackout. The word forget is also a helpful concept in one's attempt to understand, in any given alcoholic, the meaning and purpose of his blackout experiences. Here, it appears that he is apparently aware of what's going on about him in sufficient degree to be able to do many things, like driving a car for example, often for hundreds of miles, and yet to completely forget what has transpired over a prolonged period of time. To his fully concious sober brain, the memory of this period of time is a complete blank. Others may tell him what he has been doing, or he may suddenly "wake up" so to speak in a strange place, wondering how on earth he came there, but totally unable to recall how. This particular forgetting action of alcohol in the blackout serves an important function for the alcoholic. An example will serve to illustrate the point.

One patient told the story that on one occasion, he was out in town on a drinking bout when he was informed by the local bartender that he had called the boy's father to come take him home. Having experienced this embarrassment before, and being unwilling to go through it again, the young man fled the pub. At the point of leaving the building, the young man blacked out and recalled nothing until he "awoke" the next morning in a jail cell, wondering how on earth he came to be there. It was then that he was informed that shortly after he had left the bar, he had encountered an elderly gentleman whom he proceeded to viciously attack in an unprovoked manner. Questioned closely about the incident it became obvious that the young man was not denying any knowledge of the incident but that in reality he had actually been blacked out, and apparently had misidentified the older man for his father and had, in his drunken state, attacked him and did him harm.

A review of his past history indicated that he had blacked out many times before, so that it was easy to see that it was a well-established psychologic mechanism that served him well in times of emotional stress. It can be seen then that the effect of alcohol on the memory mechanisms, ordinarily quite easily observable in the inebriated individual, can, after a longer period of drinking, be extended and enlarged to longer periods of time and events to cover those actions and experiences one would wish *not* to remember. Black outs do not *just* occur. They occur for a reason, a conflictual psychologic reason, which alcohol assists and facilitates by its action on the human brain The blackout experience is the natural psychological and physiologic extension of the well-observed forgetting phenomena seen in the acutely intoxicated individual.

It should be enjoined again that, although this paper is about the psychological and physical effects of alcohol on the individual, it should be apparent by now that the all-important psychologic effects are the result of the actual physical action of ethanol on nerve tissue. To the pathologic drinker, it is the psychologic effects that he drinks to obtain, and soon learns how much is required to produce the effect he needs under any given stress situation. On one occasion, for example, he may be restless and unable to sleep. He will therefore consume enough to help him get off to sleep, and, incidently, will have an adequate supply on hand to be certain that should he wake during the night there is enough to get him back to sleep again, and yet again even enough for the morning "snort" to calm his nerves for the work day ahead. Or he may even need it during the day in small amounts to enable him to tolerate his work. The example comes to mind of a patient who came to the Center who had used alcohol for 20 years in this way. For 25 years he had held a job as an official inspector of dressed chickens. For eight hours a day, literally without a break, he would sit and inspect one chicken after another as they moved by him on

a conveyor belt at a rather rapid rate. In order to do this it was necessary for him to remain inebriated just enough to tolerate the business during the day, and at night to really drown his built up tension so he could "forget" both days—the one he had just worked and the one coming up. Another man, for example, had to have some alcohol in order to disinhibit himself enough to work as a tree surgeon. He called it giving him "courage" when, in reality, the alcohol was acting to blank out the known dangers of the job; that is, to disinhibit him just enough to forget and to disregard the dangers involved.

Alcoholism: A Learned Way of Life

How the so-called alcoholic becomes the compulsive drinker is really not such a mysterious phenomena. He learns to become so. Addictive type drinking is a learned behavior pattern or way of life that becomes as natural to the person as the autonomic function of breathing. He begins early in life by discovering that a certain emotional or milder physical discomfort is rapidly ameliorated by the use of alcohol. Soon he learns that it works well also for other uncomfortable situations, offering him at least a temporary surcease from his difficulties. He has then begun his pattern of drinking, learning by alcohol's never failing ability to work in practically every stress situation, an always available self-prescribed remedy for whatever ails him. He is on his way, each use of it more deeply ingraining the well-learned habit, which comes to require no thought, only reflex action to reach for the Nirvana-producing magic liquid. After a shorter or longer period of adjusting to the stresses of life by chemical means, the tragedy of attempting to perpetuate the temporary state over prolonged periods of time begins. Addiction to alcohol's euphoric producing or other psychically needed effects is then complete. The philosophy of life called alcoholism has become well-established for him and requires a constant supply of anesthetic to prevent its revengeful awakening. What began as a slowly developing psychologic addiction has also developed into a physiologic dependence and the circle is complete. He is the full-blown alcoholic.

Treatment

The treatment of the alcoholic falls into three well marked phases: the treatment of the acute phase, or the detoxification process; the convalescent phase; and the last, longest, and most difficult —psychologic, social, spiritual and economic rehabilitation of the patient. As with any other illness, a lack of attention to any significant etiologic factor in the treatment continuum can spell relapse and possible disaster to the patient. Conversely, inattention to certain obvious irreparable changes in a given patient can often result in the production of false hope in the patient as well as in his spouse or family, cruel in itself, and also a lot of conscience-slaving but wasted effort on the part of well-intentioned helping persons. It becomes of tremendous importance then that those who work with alcoholics in a non-medically supervised setting have an acute awareness at least of some of the more outstanding medical and psychiatric danger signs that present themselves in the course of these relationships. In our brief presentation of the three phases of treatment, we shall point these out in order that appropriate referral or consultation may be effected.

The Acute Phase. The non-medical professional has little business attempting to do anything with the acutely-intoxicated individual, except to get him, in the event he becomes involved, into a protective setting for withdrawal purposes. Preferably this should be a medical setting because he represents a medical problem.

Depending upon the length of time he has been drinking, and upon the intensity, lack of adequate food and fluid intake, degree of exposure, and age and many other intercurrent factors, the acutely intoxicated individual is actually a serious medical problem and in need of expert care. It would be naive to think that even a small portion of withdrawing alcoholics ever receive such care. It is common knowledge that most of them effect their "coming off the stuff" on their own by "toughing it out" or "tapering off." For some the withdrawal is effected in jail. But this is not as it should be. In reality the hospital is the place for withdrawing the more seriously ill alcoholic where he can be kept under medical surveillance for the possible serious complications of delerium tremens, convulsions, severe dehydration, pneumonias—which are especially severe in the alcoholic—and a host of neurological complications which can be improved by prompt and specific medical therapy. In those communities where there appear to be unwritten codes of the local hospital which prevent the admission of these seriously ill persons, it should be considered one of the goals of resident social workers to challenge these unwritten policies and prejudices of the local hospitals in order to effect a change. It is obviously true that many withdrawing alcoholics can safely be "dried out" at home with proper medical care.

However, to exclude even the very sick alcoholic from adequate medical care on the basis of sheer prejudice is totally unjustifiable. Certainly it is not the job of the social worker to become involved with the medical treatment of the acute phase. However, it can be one of his goals to work toward the alcoholic's getting the treatment he needs.

Treatment: The Convalescent Phase. Because the alcoholic has apparently come through the acute phase of his illness is no reason to assume that he is a fully functioning individual. Those physicians who work at the center where the majority of admissions are exactly in this stage of their illness are constantly amazed at the deteriorated state of the patients. They are a long way from their best possible physical health, and most of the time the full month of treatment at the Center is required to get them on their feet again. For example, practically 100% of the patients cannot sleep and have not slept for days. In our experience we know that normal, unaided sleep will return, and almost always does. It also tells us that the effects of alcohol and the always concommitant starvation that goes along with excess alcohol use, far outlives the presence of alcohol in the brain. We are constantly confronted, in this convalescent state, with many of the signs and symptoms of the vitamin deficiency diseases such as pellegra and the dry-beri beri syndrome. Skin conditions, namely the "itch" abound. Leg pains are frequent, and of course, anorexia is very common. Weight loss is practically always present in greater or lesser degree. And this constitutes only a partial list of the continuing medical problems that confront the medical staff, many of which are well hidden by the mass of tranquilizing drugs they appear with, and which appear as we take the patient off the drugs. It is far too commonplace to see patients coming to the Center as drunk on Librium, for example, as he ever was on alcohol. This is not treating the alcoholic, it is substituting another agent for alcohol.

It is especially important to understand that there *is* a *convalescent phase* to any prolonged drinking episode, and that the handling of the individual during this phase of his illness can be a critical point in the recovery process. The convalescent phase may be considered the period when the alcoholic is most likely to relapse—for physical reasons alone. Living with them day by day, and being called on to treat the multitude of neurological and psychological disorders that make their appearance as their nervous systems begin to repair and function again, alerts us to the pure misery that they go through in this period. Their nervous systems are repairing themselves and serving their original function of transmitting nerve impulses, which they appear to do with a vengeance. The diffuse malaise and weakness of the starved state is almost always present. Anorexia nervosa (the shaky unhungry stomach persists) is present in many. Constipation and diarrhea often assert themselves. Leg pains, drawing sensations, parasthesias (tingling or numb feelings) are often present. These and many other symptoms are often present and often masked by the use of medications which keep them from experiencing these symptoms of convalescence from what is essentially a toxic poisoning of the nervous system. It is no service to the alcoholic to forever keep him on drugs. He must be taken off *all* neuroleptic medications gradually of course, and safely, in order to see what his basic state is like. One can then accurately evaluate his physical state and treat the basic underlying disease states, rather than to hide them with neuro-depressant drugs. In essence then, the convalescent phase of an acute alcoholic episode is longer or shorter depending upon the length and intensity of the episode. It is a period where continued and often intensive medical treatment is required for optimum physical improvement. For the average case that passes through this Center, admitted directly from general hospitals where the acute phase has been treated for a week or more, the convalescent period ranges from two to three weeks. Usually by two weeks all neuroleptic drugs are withdrawn, active medical therapy has been in effect, weight gains are established, normal unaided sleep patterns are established, and psychological therapy is begun.

Again it is important to realize that during this convalescent phase that any counseling or psychological therapy must be timed to the ability of the patient to participate in it. It is perhaps wiser to begin on an entirely supportive level, or as it is called "feeding" them with factual types of material even as one does in the physical treatment. During the treatment program at this Center, the first 10 to 14 days is occupied with constant medical attention and more educative type group sessions where the staff does the most giving or "feeding" so to speak. It is well known that the alcoholic has intense oral needs, especially when he is withdrawn from alcohol and, in an environment where he can't get it, if one is going to keep him in a voluntary situation, one is going to have to fill some of these needs, initially at

least, both by physically and psychologically feeding him. Only gradually can one move into the period where one can expect the alcoholic to begin to do much "giving" in any therapeutic situation. In short, push too fast, don't feed enough, and you'll see him no more. His physical illnesses and his painful psychological conflicts are so prominent in his mind that they require balm, and often a lot of it. One must be prepared to accept this role for at least a period of time to establish the relationship. Only later can one begin to work through this admittedly overdependent relationship. As one person has put it, "If you don't do some caring for the alcoholic, you'll never get to treat him."

The convalescent period also is that time during which, by contrast with the misery of his acute state, he feels so much better that he swears off ever taking another drop, and his denial of lack of control is able to re-assert itself. He can say that he's fine, he's o.k., he'll never touch another drop, he's on the wagon, he's got the problem licked—and the professional resource person is so often taken in by this bit of psychic perjury that the opportunity for getting him into therapy is lost. Again he has received symptomatic treatment, necessary beginning medical rehabilitation, but any necessary intervention of a psychological nature into the emotional causations of his illness he skillfully avoids with his denial-defense mechanisms. It is precisely at this time, however, that he needs to be strongly encouraged to enter into further treatment. Outpatient treatment may not suffice for him, depending upon whether or not he is able to remain sober. If he cannot break the habit, it may be necessary to hospitalize him for a period of time in order to get him away from alcohol and to get him a start in treatment.

Treatment: Extended Therapy. The logical sequence of the treatment of any chronic illness, such as alcoholism, after the acute and convalescent phases have been successfully carried out, is extended therapy or follow-up care. An analogy of the ideal care of a person with chronic lung disease will illustrate this point. Regular follow-up visits are indicated, more closely spaced after any acute exacerbation, with repeated examinations, chest films, studies of the bacterial flora, pulmonary function tests, etc. So also it must be with the continued care and treatment of the alcoholic, only the scope of that care must be so much broader. He must learn to avoid the agent of his disease, alcohol, just like the person with chronic lung disease must learn to avoid colds and other infecting agents. Contact with alcohol will surely and inevitably lead him right back into an acute exacerbation of his illness possibly requiring hospitalization to enable him to recover. The older he is the more likely it is that he will require hospitalization for his exacerbations.

Alcoholics do not tolerate physical illness well, either physiologically or psychologically, and need medical attention quickly before they prescribe for themselves—a practice all of them have been doing for years. Two of the most successful general practitioners with alcoholics that this writer is aware of are men who, when the call comes for help, be it from an alcoholic break-over, or for some other physical distress, are quick to respond. They know only too well that the alcoholic's tolerance for pain is practically nil, be it physical or psychological pain, and that especially during the early period of his follow-up care, it must be relieved promptly and adequately. Why? Because he knows a self-prescribed medicine that will at least relieve him if not cure him very rapidly.

The psychological therapy that the caseworker's relationship represents with the alcoholic is broader in a sense than the social worker's role with the alcoholic in a specialized institutional setting. With the alcoholic the therapeutic relationship may well be described as essentially supportive with a minimum of interpretive exercise. The alcoholic to be sure, if he can tolerate the one-to-one relationship, will unconsciously endeavor to exploit the relationship in his usual overdependent manner, seeking advice (which at times must be given), or other help like getting him a job, or intervening with his wife for him, etc. But it is unnecessary to go into the philosophy and practice of social casework here. The dictum that the social worker, through his training, learns those techniques that enable him to help any client to grow to the point where he can help himself are as valid with the alcoholic as with any other client. Some of the differences in working with the alcoholic already are outlined in previous sections of this paper.

Surely in social casework, one must needs recognize the important role of the family which is always directly involved emotionally and economically. Discussion of the points and techniques to be considered here are amply treated in other sections of this manual. It is a longer or shorter process, depending, of course, upon a multitude of factors, each of which may require assistance of all sorts. The relationship with the alcoholic and his family may be expected to be a continual type of contact for many years, like any other client.

NOTES

BY MORRIS E. CHAFETZ, M.D.

THE NATURE AND TREATMENT

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The arrival of alcohol on the scene for mankind is not part of recorded history. Although its birth was unnoted, its infantile and adolescent period ignored, its maturation has not passed unnoticed and will continue throughout civilization to be a "genie" of good and evil. What is this liquid which infuses the human animal with valor or fright, elation or depression, withdrawal or aggression, sexual impulse or frigidity, psychosis or sanity, gratification or destructiveness?

Pharmacologically, it is a central nervous system depressant which depresses irregularly downwards, the higher centers being affected earlier and the lower and more primitive centers later. Its effects are similar to other general anesthetics, but because comparatively it is removed by the body so slowly, it is a dangerous drug to be used for the purposes of anesthesia. Its so often sought-after stimulating effects are in fact a depression of higher inhibitory centers that result in freer expression of more primitive impulses.

Now that we have briefly visualized the agent, let us look at the effects alcohol has upon us in our social contacts. The importance of alcohol's role in social structuring need not be pointed out to you, but perhaps some elaboration of its significance will be essential. History has recorded innumerable instances of alcohol helping to shape the outcome of various events. Horace wrote ages ago,

> **What wonders does not wine ! It discloses secrets; ratifies and confirms our hopes; thrusts the coward forth to battle; instructs in art. Whom has not a cheerful glass made eloquent; who not quite free and easy from pinching poverty.**

Shakespeare's references to alcohol and emotional responses are many. Alcohol is utilized in our culture in almost all areas. Have a new child, and his future, his health and your share in his parentage will be toasted with a form of alcohol. Marry, graduate from social work school, or be invited to give a lecture and alcohol will be there, too. Be born a Jewish male, and one week later at your circumcision someone's little finger, dipped in wine, will be inserted into your ever-seeking mouth. Watch Catholic Mass, and the priest would be hard pressed to complete the ritual without

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wine. Visit the Italian in his original cultural surroundings, and wine will assuredly grace the table. Visit the 20th century American home socially, and one hand of the host will reach for your coat as the other hand proffers you an alcoholic drink. Win a baseball pennant, and the papers will describe the popping of the champagne bottles. Buy a fancy dress for evening wear, and it's a "cocktail" dress. Use the phonetic alphabet, and the word for "w" is whiskey because of its universal familiarity. Listen to music and you will hear "Drink to Me Only With Thine Eyes," "Lips of Wine," etc. Even the conservative older generation is involved, for they love Lawrence Welk and his champagne music.

Obviously we could all go on and think of other areas where drinking is an accepted part of our cultural life. You have all heard the wise admonitions of safe driving groups who say, "don't drink and drive," and yet many legislators and police authorities say it's all right to drive and drink. They imply this when they use the level of .05 millimeters per cent alcohol in the blood as the determinant of the ability of an individual to drive a car, having partaken of alcohol. In other words, drink and drive, but don't let your blood level get above .05. Of course, I could next show you alcohol's influence and omnipresence in some of the disorders of 20th century American culture —the percentages of arrests relating to alcohol, the number of crimes, suicides, the job losses, family breakups, sexual assaults, physical infirmities—where alcohol has played no small part. Therefore alcohol must be and should be viewed as a potential for good and evil.

Because of our particular orientation and in view of the subject of our talk, we are going to narrow our focus on a large group, in terms of numbers, for whom alcohol is a psychological and physical poison. We must, however, keep in mind that comparatively speaking this population is a small percentage of the alcohol users of our society. I emphasize this point because the alcohol is not at fault in the condition known as "alcoholism." It is merely the symptom choice of the external and internal environment. Most certainly there are pharmacological effects of alcohol which produce the physiological responses which fit into the psychological economy of the individual, but that is of secondary importance.

What is alcoholism? This is a question which has plagued physicians, scientists, moralists, and others for centuries and which continues to haunt all our efforts to delineate and define the problem. It is almost axiomatic that one can more readily deal with a problem that is clearly seen than with an ill-defined condition. Recently an NIH grant of substantial size was awarded to develop a nomen-

clature and define the problem. The researchers have no small task. I give you the World Health Organization's definition:

> **Any form of alcoholic beverage drinking which goes beyond the traditional and customary dietary use or the ordinary compliance with social drinking customs of the whole community irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution, or acquired physiopathological and metabolic influence.**

Our definition is as follows:

> **A chronic behavior disorder which is manifested by undue preoccupation with alcohol to the detriment of physical and mental health, by a loss of control when drinking has begun (although it may not be carried to the point of intoxication), and by a self-destructive attitude in dealing with personal relationships and life situations. Alcoholism, we believe, is the result of disturbance and deprivation in early infantile experience and the related alterations in basic physio-chemical responsiveness; the identification by the alcoholic with significant figures who deal with life problems through excessive use of alcohol; and a socio-cultural milieu which causes ambivalence, conflict, and guilt in the use of alcohol.**

At our clinic at the Massachusetts General Hospital we have used two broad categories into which to classify our patients. While we have certainly recognized the limitations of all classifications systems, we have found it necessary to use the groups of "reactive" and "addictive" alcoholics as a means of aiding us in the definition of the problem.

Reactive or neurotic drinkers usually have relatively normal pre-illness personality structures. When they utilize alcohol to excess, it is because they have become temporarily overwhelmed by some external stress. When one examines their life patterns retrospectively, one sees a reasonable adjustment in most of their areas in which ego strength can be measured. They have maintained reasonable family relationships; they have completed their educational goals; work and social demands have been met; and generally speaking, there has been a reasonably progressive movement toward realistic goals throughout most of their lives. Drinking for these people is usually associated with observable external stress situations, most frequently of long duration; and their excessive drinking has a determinable onset, usually runs a course very consistent with some tension release, and may even terminate through some measure of self-control. However, some of these so-called neurotic drinkers may become so involved with alcohol that regressive phenomena

Gross disturbances

set in which approximate the behavior of malignant or addicted alcoholics, and this results in a very difficult problem of differentiation. Usually, in terms of management, routine forms of psychotherapeutic techniques such as are used with other neurotic disorders can be successfully employed.

When we look at the alcoholic addict, on the other hand, a rather different picture presents itself. When one studies the alcoholic addict over a long period of time, one recognizes that there have existed gross disturbances of his prealcoholic personality structure. There have always been difficulties in interpersonal adjustment during the early years, and these are usually manifested by poor relationships within the family, school adjustments, poor work history, and very frequent marital difficulties and break ups. Also, strikingly, there is no sharp distinction to be seen as to when the loss of control over drinking took place, and frequently there are almost minimal observable stress situations associated with the onset of drinking. Most often the need for drinking seems to arise from within the individual and to a casual observer these needs seem to have no rhyme or reason. Also the drinking bouts of the alcohol addict will usually continue until sickness or stupor ensue, and most of the drinking and events surrounding it usually have a strong self-destructive component to them.

While it is well known that alcoholism can occur in any personality structure, and that each patient must be studied individually to understand the personal dynamics motivating his drive toward addiction, certain common denominators seem to exist and have relevance to the psychotherapeutic approach. In terms of analytical classification, we consider addictive alcoholism as an oral perversion. By oral perversion we mean that due to traumas occurring during the earliest stage of psychosexual development, emotional fixation occurred at that time when the individual's means of achieving security and release from tension was by means of stimulation of the oral cavity. We recognize that there may have been a heightening of oral gratification as a result of constitutional factors, which tended to increase the intensity of these oral drives. This may be seen in the habit pattern of the people we have studied, since they devote so much energy toward excesses in drinking or eating, smoking, pill taking, in their

fantasy and sexual life they emphasize the mouth in much of their activities, and generally focus at all times on gratifications which dynamically are considered oral in nature. Interestingly enough, when one patient who had been in therapy for six years was asked by a friend what her therapist looked like, she reported that she was amazed that she could only remember that he had a beautiful mouth, and could describe no other feature of him.

Because the addictive alcoholic gratifies his instinctual oral wishes directly and without anxiety, this is recognized as a perversion rather than as a neurotic mechanism, which is a disguised, anxiety-ridden converse of a perversion.

Now we must ask what factors played a role in the fixation at this early level of emotional development, and we seem to have confirmed the findings of others that this fixation was the result of a deprivation of a significant emotional relationship during these early years of life. This deprivation most frequently was the result of an emotional absence, a physical absence, or death of a key figure during this early period of development. In our group, many addicted alcoholics were abandoned illegitimate children. Others were the children of psychotic mothers, while still others had had parents who died shortly before or after the patient's own birth, and still a sizeable group were the offspring of parents who had been severely alcoholic during the patient's early years. A very small percentage of these addicted alcoholics we have looked at were the children of overindulgent and extremely protective mothers who expressed in this way their underlying, disguised hostility. Fundamentally, the common thread running through these relationships was the absence of a warm, giving, meaningful relationship with a mother figure during this period.

I should now like to present to you two brief case histories of patients treated in our Emergency Ward Alcohol Unit. The first patient is a 19-year-old, married woman referred to our unit because she needed help in finding a place to go after she left the hospital. She had arrived at the Emergency Ward ostensibly because of a cold and sore throat, but history and examination revealed a drinking problem, and we were called in.

Mrs. C. is an attractive young lady who refers to herself as a child who has been living alone, waiting for her husband to complete a six-months jail sentence. His incarceration stemmed from an old illegitimacy charge, and he received the maximum sentence. She missed him terribly and counted off each day which brought him closer to return. The husband had by a previous marriage three sons— 9, 5 and 3— whose care has been the responsibility of the patient. Because of the patient's drinking and her insufficient income from waitressing, her mother-in-law is presently caring for the children. Mrs. C.'s 30-year-old husband, when out of jail, is a construction laborer. The patient married him 2 years ago when she was 17, after having run away from home and having lived "here and there." The patient was adamant against giving the name and location of her parents and was especially vehement in her denunciation of her mother. Her nine siblings are described as passive and emotionally disturbed. She cried, "I was the only one who had the guts to do something about the family situation." One brother has been in and out of state hospitals, a sister has had several illegitimate children, and another sister is described as "off," always trying to hit people on the head with a frying pan. Another brother at age 13 is in the Lyman Correction School. The patient herself was institutionalized at age 14 in a correctional institution as a "stubborn child" and was delivered of an illegitimate child, now 3 years old.

Mrs. C. describes herself as lonely and depressed and states she began drinking increasingly one year ago. She feels an increasing need to stay by herself and consume whiskey until she is stuporous and falls asleep. She has made some attempts recently to stop drinking but is unable to because of the sick and frightening feelings which ensue. Without friends ("they get me into trouble"), the patient has only alcohol as her solace. This is not surprising since her mother was "always loaded." She is unable to establish a relationship with her husband's family because of a difference in ethnic background. Mrs. C.'s status is also complicated by her being 7 months pregant without having received any prenatal care.

The psychiatrist and social worker of this patient were able to quickly establish a relationship and by utilizing their liaison with community agencies, located an uncle with whom the patient had lived happily until she was age 6. He agreed to take her into his own home and care for her until her husband's release from prison. Contact with a maternity hospital was effected, and the patient's anxiety about attending the maternity hospital abated when the worker from there made the first contact with her in our institution. Mrs. C. continues to see our psychiatrist and social worker on a weekly basis and has discontinued drinking; her depression has also lessened.

Second Case

Our second case is a 31-year-old, married male who was referred to our unit because of a problem of alcoholism associated with acute fears that people are going to kill him. Although he has had a 17-year history of alcoholism, the character of his drinking

has changed in the past few months. Whereas formerly he would be thoroughly intoxicated throughout the weekend only, now he gets drunk daily. His disintegration began about the time of the birth of his last child, a boy. He has three other children, all girls.

Along with his drinking problems and fear of being killed, the patient is continuously anxious about his children. His oldest girl is arthritic, the youngest was hospitalized with pneumonia for two months, and he has the idea that his wife has leukemia and will shortly die. He himself has been hospitalized for removal of an ulcer, third degree leg burns, blood poisoning, and pneumonia. Prior to appearing at our unit, the patient attempted unsuccessfully to have himself committed to a mental hospital. As a consequence of the patient's intense anxiety and the difficulty of deriving information from him, an interview was held with the patient's wife.

Whereas Mr. L. was a small, immature, passive-dependent man, his wife was big, overweight, and calm. She volunteered that she had a splenectomy recently for some blood disease which caused blotches on her skin, which her husband was convinced was leukemia. Although she originally appeared calm, the interview revealed that she was nervous, bothered by the children, and when worried, over eats. She has a relationship with a social worker at the hospital where she had her surgery performed. This relationship was evolved in an attempt to learn how to deal with her husband's drinking. She reports that her husband is wonderful when not drinking, but in the past few months he has not been without drink. He also has the strange habit of hiding alcohol in other people's yards. He also has great difficulty in sleeping and spends the night cooking and spilling grease and food on the floors. His behavior on occasion resulted in the police coming to their home. The patient also has the uncomfortable habit of hiding open beer bottles in her clean laundry, which means she must redo the wash. He has also burned the sofa, mattresses, and curtains by carelessly leaving cigarettes lying around. His father, whom he knew only by hearsay, was an alcoholic. Mr. L.'s parents were separated when he was age two and one-half, and he was raised by an aunt who is a long-standing patient in the mental hospital into which he attempted to have himself committed.

Reality problems are many. Bills are multiple and high. Rent and food money are minimal, and Mrs. L. is trying to get her brood into a housing project. At present there is no heat in the house. Last Christmas she became so agitated that she threatend that if her husband came near her, she would stab him with a knife. He did approach, and she plunged the knife into his chest, penetrating a lung and necessitating his hospitalization.

This history possesses an enormous amount of pathology. Many community agencies and hospitals were involved and there was no integration of planning or services. We did not wish to interrupt Mrs. L.'s excellent relationship of long standing with her worker. The children have workers interested in them, but Mr. L. refused to admit that he was sick or alcoholic and needed help. Our function, as we saw it, was to become the central source in this family's care by notifying all agencies involved, collecting the massive information into one place, and, by centralizing the endeavors, to present to the family and the caretaking agencies an integrated and unified approach to the problem. Although Mr. L. has not yet arrived for help, the community involvement on this family's behalf is such now that more intelligent, coordinated planning is possible for each member and especially for the father should he ever seek treatment.

If one accepts the psychodynamic formulation for the addictive alcoholic to which we have formerly referred, and one visualizes the intense activity and acting out involved in the brief case summaries we have just presented, then the therapeutic difficulties become apparent. Most primitive disorders are treated within the protective and supportive confines of an institution. Not only does the addictive alcoholic suffer primitive psychological disorder, but there is, as you have seen, a great tendency to act out conflict situations. Hence to attempt to treat him psychotherapeutically on an ambulatory basis can be fraught with danger.

This danger, we believe, lies in two main failings: first, there is a tendency for most therapists to maintain rather rigid therapeutic approaches in which their training has emphasized the limits of their role and their behavior. The second is the over-generalized classification of alcoholics as hopeless character disorders and hence untreatable. The person who is prepared to deal with the alcoholic must be prepared to be a pioneer in his approach to each case, whether he is a psychiatrist, social worker, or counselor. Fundamentally, he must be a warm, kind, interested individual who can at the same time set and maintain reality oriented limits. He must not and cannot assume moralizing and punitive attitudes. Since we are dealing with a disorder of early development words tend to be of little use. It does not take one long to become aware that it is not what one says to the alcoholic but what one feels and does that will determine the outcome. Since, therefore, it is a preverbal disorder, it should be so treated—by action, by doing for the patient. Although he wants help, all of his emotional life experiences

warn and threaten him against entering into relationships where rejection is the inevitable outcome.

When one speaks of "action" or "doing" therapy, what specifically is meant? What is meant is that if the patient requires physical treatment, then hospitalization, medical care, should be readily provided. Prescriptions for vitamins or antabuse may be meaningful when the patient is seeking evidence of tangible support. Helping out with particular social problems which may have arisen and complicate entering into a treatment relationship may be another tangible method. In other words, one must be a very active therapist in the early relationship. We have found that the passive, non-directive therapist of alcoholics usually has no patients to treat after a while if the usual therapeutic approach is employed. In all therapeutic situations dealing with primitive problems, a positive relationship is of prime importance. Without this firm bond between therapist and alcoholic, no exploratory approach can hope to succeed. This bond may take a few interviews or several years to develop, but it cannot be bypassed. When it appears to be firm, the patient will test it again and again, and even when the tests are passed, the bond will be tested further. This means that the patient must be offered help again and again, no matter how often he fails and resorts to alcohol. Since these patients are fundamentally so hostile, their behavior is unconsciously designed to arouse negative feelings and invite retaliation. This should be a major concern of all treatment personnel, and it must be constantly guarded against. Counterhostility is frequently expressed by being overly friendly or excessively permissive. Since these patients are already leaning toward loss of control, the absence of controls by the therapist is poorly tolerated and most threatening to the patient. It really indicates to the individual a lack of understanding of the basic problem, and raises the identification of loss of control with loss of contact with reality, resulting in further regression and disintegration of personality. Anxiety in any treating personnel is interpreted by the patient as evidence of insecurity and uncertainty of control. Of course the hostility present in a therapist who is rigid, harsh, and punitively controlling is self-evident. The attitude of tolerant acceptance with consistent firmness is healthy and reasssuring. One must maintain a position of constancy and honesty, acknowledging to the patient mistakes, errors, and feelings arising within the therapist as soon as he, the therapist, is aware of them. When the patient makes a demand, an oversimplified but safe question to ask of one's self is: "Is what I am doing really for the patient's good, or am I doing it to make the patient like me?" This will be especially pertinent when the patient, besides inviting punishment, attempts to seduce the therapist to prescribe drugs or other dependent gratifications.

While the therapist must be an active, continually supporting substitute for the alcoholic, we are ware of the insatiable demands of these patients. Few human beings can long endure the pressures, hostility, and acting out of conflicts which are so much a part of the alcoholic's treatment. It therefore becomes apparent, as can be seen in the cases we have presented, that the most appropriate method of treating these patients is within a hospital setting, with a team approach: psychiatrists, social workers, psychologists, general physicians and specialists of other sorts.

The social worker is all important in this team because she should be available to help with the financial, family, and social pressures that so commonly arise to interfere with treatment. At our clinic the social worker usually makes the first contact at the intake interview. Therefore her approach often sets the tone for the clinic patient. Frequently we are able to establish a relationship with a given patient only because a devoted worker spends much time making brief daily visits to depressed and withdrawn patients while they are still on the ward. The social worker in a number of instances provides the most meaningful contact to those patients whose problems require that they have a relationship with a woman. Other times it is well to split the transference situation of the patient by affording opportunities for interviews with a doctor and a social worker, or sometimes more specifically with a female worker where the therapist is male. At other times the social worker serves another part of the program by seeing the spouse while the patient is seen by the doctor.

In broad outline, once a satisfactory relationship has been developed, one must then wean the alcoholic from his dependency needs to a gradual recognition and acceptance of reality factors. Once the drinking is controlled, the therapist must avoid the tendency to continue the now outgrown protective attitude. There must be emphasis on encouraging him to carry out tasks, make decisions, and consistent with the patient's abilities,

meet and deal with reality in a mature manner. Situations which reactivate emotional reactions associated with the patient's original rejection are common pitfalls which treating personnel must avoid.

One other point—in deciding about the course of treatment for an indivdual patient, one must establish realistic goals. For some patients, the relationship and the imposition of external aid and control over drinking is all that can be tolerated. Others may require partial custodial care and more continuous support. However, many others are able to tolerate more intensive exploratory uncovering psychotherapeutic approaches with resolution of the transference as its ultimate goal. One must set up the goals within the abilities and the capacities of the patient and base them upon a keen evaluation of the patient's makeup and many clinical hours of amending or confirming these preliminary formulations.

Our experience has shown us that in the total care of the alcoholic, his family and surroundings cannot be neglected. More and more we recognize that although a superb therapeutic encounter with the patient takes place, his or her return to surroundings which have remained static and precipitate drinking behavior negates or minimizes successful treatment. With this view and understanding, caretaking agencies in the community, places of work and contact with the family members assume an even greater importance than formerly realized. In the present as well as in the past, specialized alcohol units had to deal with not only the patient but also assumed the responsibility for the care and treatment of affected intimates of the alcoholic. The obvious result is further taxing of overtaxed facilities and a dilution of the special talents of the highly trained therapist in alcoholism. Not only did this overtaxing and dilution result, but it was physically impossible to study the natural milieu of the patient. Hence, incomplete understanding of the patient was the rule, and discouraging relapses were common. And, ladies and gentlemen, may I point out that discouragement in the treatment of alcoholics is not a rare occurrence.

On the other hand, if the specialized alcohol facility is permitted to establish an intimate working liaison with community agencies and facilities, what new potential arises! The heavy burden is distributed and more gratifying endeavors ensue. Not only is the patient treated, but simultaneously environmental stresses are being removed, and this aids in strengthening the treatment effort. Not only does the alcoholic benefit, but often the

community as a whole. No caretaking agency is without multiple problems directly and indirectly resulting from alcoholism, and the successful control of the pathological drinking behavior of a father or mother produces beneficial results felt all along the line. The children are less threatened; neighbors are less provoked; and community resources are less drained. Not only are direct effects noted; indirect manifestations operate. The alcoholic in his stumbling, searching, scared way makes a big impact on the impressionable, especially children. Professionals in the field of alcoholism have been increasingly impressed with the histories of alcoholics whereby some significant member of their environment used alcohol to deal with the stresses of life. Therefore, I point out that total community involvement in the rehabilitation of the alcoholic has not only therapeutic consequences but preventive implications as well.

I should like to elaborate upon the role which social workers with appropriate medical and psychiatric coverage can play in the treatment of the alcoholic. By virtue of the social workers' knowledge of the family dynamics, they are in an enviable position to inform and direct the specialized agencies as to the specifics of the problem. Also, a community-based social worker is much more aware and knowledgeable about the availability of community resources than hospital personnel; and further, where appropriate, field visits by the social worker to the family and patient in the home or community are invaluable. As I noted earlier, the importance of free but judicious use of a wide variety of community resources in the rehabilitation of the patient and work with the family cannot be overemphasized. But it must be stressed that the planning of the therapeutic regime must be undertaken by one central caretaker, or else the alcoholic, in his unconscious acting out, will play one agency or individual off against another with disastrous results.

The necessity for establishing workable, natural liaisons with other agencies may be illustrated by our own experience. When, in 1959, with government funds, we undertook a research project in evaluating the efficacy of establishing a healthy, initial therapeutic contact with the alcoholic, we recognized early that we would be dependent upon other agencies outside of the hospital. True, a document listing many seemingly available facilities for the varied needs of the alcoholic existed.

Closer scrutiny, however, revealed that the rules and regulations of these agencies were so designed that they excluded completely those patients who most require their services. For example, some required extensive periods of sobriety prior to admission, or extended periods of residency in one locale, or a continuous occupational history, or the presence of a family, which in effect excluded alcoholics. It became essential, therefore, for members of our research group to survey each and every facility, recognize positive and negative potentials therein, and then establish liaison whereby in return for accepting our patients in circumstances outside their rules, we offered consultation service to the institution as well as continuous interest and support on behalf of any of our patients under their care. The results in terms of our needs were most gratifying, but as an added dividend, destructive attitudes rampant in these institutions were minimized when the caretakers saw and were involved in the tangible responses of the study.

By consideration of an approach whereby the alcoholic himself is seen in a "specialized alcoholism facility" but the care of the family unit is done in casework agencies in a coordinated manner, an important area of work comes into focus. Because of existing laws, attitudes and needs, alcoholics are frequently institutionalized. If community agencies interested in alcoholics were to develop more effective working relations with custodial facilities for alcoholics, they would be in an excellent and essential position to bridge the gap between rehabilitation started in the institution and rehabilitation continued upon discharge. For as our research studies have consistently illustrated to us, continuity of care and interest in the alcoholic is paramount to successful therapeutic encounter.

One last but most important role I see for community agencies. Because of your special position and your intimate knowledge of family and community, with a carefully attuned ear, you are best able to do early case finding in alcoholism. And the axiom of all medicine continues to hold true for alcoholism: the earlier in the condition treatment is begun, the better the chance for successful outcome. Therefore, by familiarizing yourselves with what specialized facilities exist, by developing a good working liaison with more agencies, and by virtue of your intimate knowledge of families, you are in the enviable position of steering the alcoholic into treatment early in his condition.

A general word about attitudes of caretaking personnel: The psychiatry of the recent past is replete with examples of cruel, moralizing and punitive treatments of the mentally ill, the stigmatized vestiges of which live in our present day. With understandable enlightened hindsight, we may look back at these ancient attitudes and complacently attribute the errors of our predecessors' ways to their ignorance. We are often, in the caretaking community, a bit smug and self-righteous and proclaim that our medical, social, and psychiatric approaches are more humane, less punitive, and certainly less moralizing. It may be true that our supposed enlightenment does exist in certain areas, but certainly when the condition of alcoholism is the problem to be dealt with, attitudes change as though practitioners of a different age are reborn. This is especially noticed when one sees in any busy emergency ward the manner in which alcoholics are handled. Other patients are generally dealt with in a kindly, tolerant, and nonjudgmental manner. Their needs are ascertained and treatment is prescribed within the bounds of acceptable medical principles. Not so with the alcoholic—he is allowed to wait and then is examined only cursorily to see if he has any "real" medical problem, often treated in a faintly contemptuous and hostile manner, and then summarily discharged and allowed to fend for himself.

I feel that medicine and its allied fields are merely reflecting the attitudes of society in general. Who wants to help the drunk lying in the gutter, wandering into the hospital, looking for rehabilitation? Unfortunately, most people respond to the alcoholic lying in the street by making the widest possible circle around him. This is figuratively the main method employed in dealing with alcoholics—make as wide a circle as possible around them, neglect them, adopt punitive, moralizing attitudes toward them. Therefore any of us in the caretaking community must constantly be on guard against ourselves in our contacts with these patients who so desperately look for aid, which is so often lacking. Only when we begin to look at alcoholism in its proper context, as a psychological illness, with alcohol as the symptom choice, can we hope to acquire a greater understanding of the process involved, and thereby evolve better therapeutic techniques.

ALCOHOLISM and the family

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Historically the family in which there is an alcoholic member most often has been viewed in one of two ways—as the primary cause of the drinking or as the martyred recipient of the drinking behavior. In one sense this view has some validity in that the alcoholic's parental family, as we shall see, may play a part in the development of alcoholism, and the family, be they parental or marital, suffers as a result of having an alcoholic member. In consequence of this rather limited view the tendency on the part of friends and relatives or those offering help has been to see the alcoholic in isolation from his family. Understanding or treatment has been provided to one or the other rather than to the alcoholic and his family as a unit of interdependent individuals each of whom reacts to and is affected by the behavior and personality of the other. Insufficient recognition has been given to the interacting forces within family life which would seem to contribute to both the ongoing drinking or recovery from drinking as well as to the instability or stability of family life. Without greater awareness of, and focus on, these forces, sobriety will be limited or unsatisfying and prevention of alcoholism and/or emotional disturbance in the next generation will probably be unattainable.

Many clinical studies have revealed that the personality of the individual who becomes an alcoholic usually is determined by early parental relationships, or, as is so often the case, by a lack of significant parental relationships. While no extensive research has been done on the family of the alcoholic, much has been done on family life in general which shows that whenever the normal growth-producing relationships between family members are limited or cut off, family life and the lives of all members in greater or lesser degree are affected. With the addition of continued or repeated excessive drinking, the chances of normal, healthy family life are less possible, or at times, impossible. Other studies would seem to indicate that there is no one alcoholic personality, but it would appear that most alcoholics do have certain common characteristics which, together with the continued excessive drinking, play a significant part in the quality of

family life experienced by all members.

Common Characteristics

These common characteristics are often overlooked in our approach to treatment of the alcoholic and of his family. They will be found in varying degrees in different individuals, are more or less evident at varying stages of the illness, and are not seen in all individuals suffering from alcoholism. Some of the most frequently observed characteristics—and those which most vitally affect family life—are as follows:

Inability to take appropriate responsibility within the family with the result that the normal household tasks, budgeting and planning of finances, care of the children, etc., are left to the wife. This may lead to growing resentment or to the wife's depriving the alcoholic member of the few responsibilities he may be able to handle. Even more difficult for the wife to accept is the man who cannot take normal responsibility for his home but who can often fulfill a relatively responsible role at his work, in his trade union, in the church or community.

A lack of self-discipline which shows up in impulsive, inconsistent, indulgent, or dominating behavior toward other family members. This might be tolerated in relationships outside the home, but it is disturbing or damaging to the closer relationships of family life.

An over-dependency which cannot be met or accepted by the other family members and which makes it difficult, or impossible, for the alcoholic to meet the normal dependency needs of his children. In some instances the dependency needs are so great that he is threatened by the birth of each child or by his children as they begin to reach adolescence or semi-adulthood. In some instances the dependency needs of the marital partner are as great as, or greater, than those of the alcoholic, which means both parents' normal needs are constantly unmet and each may turn elsewhere to find fulfillment —the alcoholic to drink and the mother to the children.

A pre-occupation with self and one's own suffering which makes it difficult, or impossible, to accept or recognize the normal needs or pain of other family members (such as the hurts of childhood, or illness of the marital partner). Very often the alcoholic parent resents the demands that these make on him, and family members feel growing resentment that their suffering is not recognized or assuaged.

A negative attitude towards authority which may prevent his holding a steady job or limit his ability to assume a healthy authority as head of the family. This may result in either lack of discipline or too rigid discipline for the children, with consequent hostility and confusion. It may also result in the assumption of authority by other members of the family, usually the

mother, or an older child.

A sense of inadequacy in certain vital areas of family life which distort the marital and parental roles. This is seen most often in his inability to find and keep a satisfying job, to experience normal sex relationships, to play or work with his children, or to relate meaningfully to friends, neighbors or other relatives.

An unrealistic, immature approach to the ordinary business of living which leads him into extravagant buying and the accumulation of unnecessary debts, limits his ability to provide for the necessities of family life, or to play a normal role in maintaining the home and providing for the real needs of family members. For example, he may buy a car when the children need shoes, repairs to home are left undone, or the family is deprived of essential outings and creative experiences.

Limited interests which tend to isolate him and other family members from normal activities. He is often addicted to TV or spectator sports in which little is demanded of him. He may resent his wife's or children's normal interests—often to the point where he forbids their pursuit. The family members may then limit themselves to his interests with consequent isolation of the whole family.

Shallow or superficial ways of relating to people which make it difficult or impossible for him to demonstrate or communicate the love and affection so necessary to the growth of family life. This may create a neurotic interdependence between family members as they try to meet his loneliness or his emptiness. The child who does not experience sufficient love in the home may learn to resent and hate, and thus has limited opportunity to grow into a giving, understanding person.

Thus it may be seen that these characteristics may limit or disrupt family life more than the drinking itself. They often may be the source of early and prolonged marital discord before the drinking became really excessive. They may complicate and add to the family problems when drinking is at its height and may provide a basis for ongoing trouble when the drinking is controlled. While the drinking episode often creates a crisis or a breaking point for all family members and gives them something tangible on which to project blame for the disruption in family life, the common characteristics which I have presented, and the family's reaction and interaction to them, would seem to provide the basis for deep and more serious limitation to vital growth-producing relationships for all family members.

The Marital Partner

Before taking a closer look at the whole family's reaction to the alcoholic member, let us consider briefly the marital partner who, in something like five out of six instances, is the wife. Most families might cope with the recurring drinking bouts if neurotic characteristics, some of which are similar to those seen in the alcoholic member, were not present or did not develop in the marital partner. In the popular view, the nonalcoholic wife is seen as a tragic, brave, long-suffering victim of circumstances who is not in any important way responsible for either the drinking or the disruption of family life. However, most wives who have been in Al-Anon or in more structured treatment admit that they were to some degree disturbed individuals when they married, or that they became so as drinking and marital strife continued over a number of years. With appropriate use of help they became able to recognize that they contributed to both the ongoing drinking and—more importantly—to the breakdown of family life. They also became aware that they could play a vital part in the recovery of family life as a growth-producing unit. In many families it has been evident that even when the alcoholic partner is not able to use treatment, the nonalcoholic spouse's new insight and self-understanding freed the children to develop and grow even in the presence of continued drinking.

Family Reaction

While certain studies have tended to show that there may be characteristic ways in which a family reacts to the fact of an alcoholic member, experience would indicate that there is no one pattern followed by all families. Each family, as well as each individual member, reacts differently in degree and at different stages of the illness depending on certain factors. These include the original health of the family, the ages of various members, the family's culturally determined attitudes toward drinking, the family's position in the community, the degree of financial security, etc. All families, however, do show some similarities in their reaction.

In most families in the earlier stages of the problem there is usually need to deny or hide the fact of excessive drinking and/or family disruption. There is a tendency to lay blame for their trouble on external factors and to seek a solution through manipulating the environment with little or no recognition of the ineffectiveness or temp-

orary success of their efforts. Fears of many kinds and degrees pervade the family members ranging from fear of what outsiders will say or think; fear that they will suffer increased or unbearable financial deprivation; fear of their inability to cope with the everyday normal problems of living; even to fear for one's own sanity. Most families at times attempt to protect the alcoholic member both in a genuine effort to help him as well as in the need to protect themselves (often unconsciously) from the consequences of his behavior—which may be loss of job, jail sentence, or danger to his life or the lives of others. All family members go through varying attempts to control the drinking. This may take the form of nagging, condemning, belittling, ridiculing, or isolating him, or by submitting to verbal or physical abuse.

Impact on Family Life

What then happens to family life under the impact of such an experience? Two major reactions seem to prevail—the one of growing, interacting hostility or resentment between all members with consequent damage to interpersonal relationships; and the other of distortion or loss of normal family roles which may leave all members overly or unduly hurt, anxious, and in conflict. In the former, for example, we may see the mother lining up the children with her against the father; or we may see the children refusing to give their usual respect and obedience to one or both parents. The children may indulge in excessive bickering or quarreling with one another or react with antisocial behavior in the community. In the latter we may see loss or distortion of normal roles as, for instance, the mother takes on more and more of the father's role with consequent loss of, or limit to, her own nurturing role. We may see some children pushed prematurely into inappropriate responsibilities such as that of pseudo-parent to younger siblings. They may be expected to contribute at too early an age to family income or to be unwilling recipients of either parent's hurt or hate. Other children may be either overindulged or overprotected by one or both parents to the point where their normal maturing process is delayed or limited.

Under such circumstances children, as well as parents, may become increasingly conflicted and may react and interact with one another in ways which are destructive to family life. The children, in particular, may suffer from a lack of parental figure or figures on which to pattern themselves. They may become unsure of themselves and may have more difficulty than usual in finding their own identity or self-worth. Their view of family life and marriage may become severely distorted and, in some instances, they may begin to take on some of the characteristics described earlier of irresponsibility, lack of self-discipline, self-centeredness, and inability to form the vital relationships so essential to their normal growth.

Of concern to all of us are the ways and means of helping a family which has an alcoholic member. Some few families may regain their former stability when the drinking is controlled. Most families will not do so, however, until appropriate consideration and help is given to the disturbance or upset in each of its members. Even in cases where the alcoholic cannot use help to control his drinking, family life in many instances may still be strengthened or stabilized. Frequently, where the excessive drinking leads to a temporary separation from the alcoholic member, appropriate treatment of the family members may make possible a healthy re-uniting of the family at some point in the future.

The Therapist

Basic to any treatment* is the quality of the helping relationship. In general the therapist* or therapists should be warm, interested, giving individuals who at the same time are able to set and maintain reality-oriented limits. They should be relatively free from prejudices toward drinking or fears of drunkenness as well as from inhibitions that prevent frank discussion of the drinking problem. A moralizing or punitive attitude toward the alcoholic's drinking or acting-out behavior can limit the effectiveness of treatment. Those attempting to help these very insecure dependent individuals should be comfortable in assuming, to a degree, the role of a good or wise parent. This may imply standing for certain values and standards; teaching a responsible way of life; giving appropriate evidence of love, support, understanding and patience while—at the same time—providing guidance, protection, and disciplined authority. As with all parents, the therapist should be able to lessen the dependent relationship appropriately and free the patient to become a relatively more independent person. With the alcoholic and his family, however—more than with most families or individuals under treatment—there would seem to be a greater tendency on the part of the therapist to either force the break from a dependent relationship too quickly or to

* The terms treatment and therapist will be used throughout, not just in the narrower clinical sense, but also to include any skilled professional help or resource in the community.

foster it too long. The therapist may fail to diagnose the degree of dependency or may fail to allow time for the potential growth process to determine to what extent the dependency should be accepted. Frequently the dependency is so great it may be a threat to some insecure or inexperienced therapists, and the more mature qualities and strengths are not fully recognized or used.

One of the greatest hindrances to more widespread use of the family approach to treatment would seem to be the resistance of some therapists. This resistance stems from many sources including an overidentification with one family member by a therapist who holds to a goal of recovery of the individual patient; a fear that a relationship with other family members may disturb or disrupt the one-to-one relationship or limit the degree of success; and, lastly, a sense of inadequacy to treat the whole family. All of these may be valid in certain instances if one sees oneself as "the" therapist, but denies the interdependent factors within family life and/or of the possibility of shared responsibility for treatment.

Shared responsibility for the treatment of the alcoholic and his family calls not only for a very real awareness and acceptance of these interdependent factors but also for constant and direct interpretation of family-oriented treatment. The family should be helped to understand that treatment is not a matter of the family members' being used as an adjunct to the alcoholic's treatment but basically one of helping all members with their own conflicts, emotional upsets and difficulties in interpersonal relationships. The wife or mother will need help to accept appropriate responsibility, not only for the part she may be playing in the ongoing drinking problem, but even more so for the continued disruption of the children's lives and the family life as a whole.

Treatment

Treatment for the alcoholic and his family must be individualized and will depend on the basic personality of each individual member, the degree of disturbance, and the level of the earlier adjustment within the family. For some, treatment may need to be more formal or structured (e.g., regular appointments in the therapist's office); for some it may be a fairly intensive relationship over a short period of time, perhaps repeated at intervals; for others it may be a less intensive one over a longer period. Certain individuals and families may be helped most adequately through one-to-one relationship or relationships. While for others—as is becoming increasingly evident—the group method is the treatment of choice. For most, however, it would seem that the use of varying individual combinations of treatment at particular stages with one or more therapists may be the most helpful treatment for the whole family.

Family-group therapy, a relatively new method of treatment, is proving increasingly effective for many families. In this method the whole family as a unit will be seen in regular sessions in the office or in the home. At different phases these total family interviews may be interspersed by interviews with one or more members of the family individually or in a group—the variations will be many, depending on diagnosis. Such family group treatment, however, provides an opportunity for more adequate family diagnosis and a quicker, more effective means of resolving the negative and often self-perpetuating, neurotic interaction between family members. This kind of treatment may give the therapist deeper insights into the dynamics of the family relationships and, as well, it may help him to more readily identify the degree of health and pathology in each member. For the family it may offer a safe medium through which each member can share his feelings, discuss his behavior, and react to one another with the kind of support or intervention from the therapist which prevents destructive retaliation or condemnation from other members. It also may present an opportunity for more honest facing of one's own part in the family disruption as well as one's role in re-establishing a healthier and more satisfying family life.

In families with very young children, help may only be given through the parents. However, in families where there are older children, direct help (with the consent of parents for children under 16) may be indicated in instances where the degree of parental illness or discord may be so great that it limits or interferes with the parent's ability to fully recognize the child's problem or to play a part in its resolution through family-group therapy. Direct help might take the form of individual counseling with each child, or it might be more appropriate to provide group counseling with siblings or with particular age groups of children from several different families.

The Team Approach

The use of many different levels of treatment by a team of therapists brings a complexity to the treatment scene. It may lead to unnecessary confusion and conflict for both the patient and those trying to help, unless, or until, the therapists are prepared to involve themselves in a relationship

with one another in which diagnosis, treatment plans, and goals can be shared. In this kind of relationship undue over-lapping or misuse of services may be avoided or minimized and a wiser and a more appropriate use may be made of the particular skills of individual therapists. Similarly no one therapist will be excessively burdened or feel that he alone must, or should, try to meet the multitude of emotional, social, spiritual, and physical problems that may be presented by the alcoholic and his family.

The team approach—particularly for those in a non-clinical setting—may appear to be too time-consuming, limiting and vague. It need not be any of these if there is an assigned or implicit leader of the team. This leader may belong to any one of the helping disciplines. He may or may not be the person who is assuming a major role in therapy but may be the person, such as the social worker, who is available more readily and consistently both to team members and to the patient. With such leadership a team of therapists (be they organized more formally, as in a clinic, or brought together more spontaneously around a certain patient in the community at large) more likely will gain the necessary sense of cohesiveness. They also can share and discuss more readily conflicting treatment methods or the negative feelings which they may have towards a patient or to one another which can be so limiting to treatment.

Goals

The broad ultimate goal of family-oriented therapy should be the strengthening of the entire family as a unit. For some families, however, this may not be possible. For example, permanent separation of the parents or increased illness of either parent may make it necessary to set a more realistic long-term goal of strengthening only a part of the family unit. The more immediate goals for most families should be to enable the alcoholic member to find satisfying or, as they say in A.A., "contented sobriety" and—perhaps even more important—to help all family members to become aware of and to deepen their understanding of what is happening to the family. Which goal is worked on first depends greatly on the individual family. In some families very little may be accomplished until some measure of sobriety is achieved. In others there may not be much progress until the emotional environment is changed or altered. For many it may be most natural and appropriate to work on both more or less concurrently. In attempting to achieve either of these goals, treatment should be focused on helping each individual to increase his self-understanding and to work through the fears and conflicts created by both the excessive drinking and the loss of family stability. It should enable each individual family member to learn more adequate ways of behaving and relating which may lessen his own suffering as well as allow him to make his maximum contribution to a stronger family life.

Summary

So we see that the alcoholic as a family member has been treated far too often in isolation. Frequently and erroneously it has been assumed that he was the only troubled member and that, if the drinking were controlled, all family problems would resolve themselves. Experience has shown in many instances that—without appropriate help for all family members—the sobriety achieved may be far from "contented". It has also become increasingly evident that just as early life experiences played a part in the onset of alcoholism, so do certain neurotic characteristics in the alcoholic and/or in his marital partner play a significant role in their ability to provide a satisfying or healthy life for the family. With deepened awareness and acceptance of the interdependent, interacting forces in the family, and more appropriate and shared therapy for all family members, treatment may become not only less discouraging and frustrating for all who are in this field, but it may provide more effective and more lasting help for countless alcoholics and their families.

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The Family Agency and Social Casework in Treatment of the Alcoholic Client

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With the growing incidence of alcoholism and the increased focus of all service professions on the treatment of alcoholics, family agency caseworkers in recent years have become more concerned about their role in relation to this illness which, in so many cases, is having a serious effect on family life. While family agencies have always had a few alcoholics on their caseloads and have successfully treated a number of these, there has been a growing awareness of the high proportion who are not helped with their alcoholism and the even higher proportion whose alcoholism is never identified or faced. The purpose of my paper is not to discuss casework treatment in its entirety but rather to consider some of the significant factors in family agency treatment of the alcoholic client. It would therefore seem important before we do this to remind ourselves of what we mean by treatment in family agency practice.

Family Casework Treatment

Treatment is a casework service to the family as a unit, even though the focus may be on individual members at a given time. Very often in work with the alcoholic client there is a tendency to treat the alcoholism in isolation, or to treat only the rest of the family. Workers often become over-identified with controlling the drinking or with the family's suffering and lose sight of the basic family agency goals of increasing family solidarity and stability; of helping both parents and all family members to accept appropriate roles for themselves as well as to accept one another's roles; of helping families to deepen the relationships within the home as well as without. Such goals may seem to some to be unrealistic while the drinking is continuing. I do not believe this need be so, if the worker is able to maintain an awareness that the excessive drinking is usually only one factor in the disruption or disintegration of family life and that other factors within the personalities and relationships of the family members are contributing both to the increasing insecurity of the family unit as well as to the ongoing consumption of alcohol.

A Case Example

Mr. and Mrs. D. might well have been family agency clients. The problem presented by the husband, a business executive, was one of excessive drinking on the part of his wife who was an attractive young woman in her late thirties. She was not ready to look at her drinking but admitted that she was troubled, unhappy and that the home was a "mess." History revealed among

other things considerable emotional deprivation in her childhood while her husband had been over-indulged in his early years. At the time of the marriage the couple seemed to be suited in cultural and social background and appeared to have a reasonable degree of affection for one another, though both had difficulty in expressing it.

On the surface things seemed to go reasonably well for the first few years. In reality there were growing resentments and tensions, but these were kept under control until the birth of the third, somewhat unwanted, child which coincided with Mrs. D.'s growing, though still hidden, dependence on alcohol. As she continued to meet more and more of her emotional needs through her drinking, her behavior sparked Mr. D's feelings, and both lost their usual effective controls. A pattern developed between them of criticism, irritability and suspicion which reflected not only the basic insecurity of both partners, but also their anxiety around the possibility of neighbors becoming aware of Mrs. D's drinking problem. Relationships with the children, which had been superficially good though inconsistent, flared into open warfare with the oldest boy, and sullen withdrawal by the small girl.

Treatment for this couple in the clinic began with the caseworker who started by helping them, not with the drinking problem, but with the behavior of the 15 year-old boy which was upsetting both parents. All three rather quickly and satisfyingly responded. Then four months of working on their marital relationship followed before Mrs. D. was ready to begin facing her misuse of alcohol, though this had been identified and looked at frequently. Constant support and interpretation was necessary to keep Mr. D. from going elsewhere for "action" on his wife's ongoing drinking. Finally the point was reached where referral to a physician and to Alcoholics Anonymous began the work of establishing some controls, a point which might have indicated closing of the case. However, a continuing, less intensive relationship was maintained with both Mr. and Mrs. D. over a period of five months during which readiness to deepen the relationship and attempt to gain some insight into her underlying conflicts and the way in which these were affecting her current feelings and behavior as a wife and mother developed. A year later Mrs. D. still hasn't achieved long-term sobriety, but the family life has been strengthened beyond what it was prior to the onset of drinking.

The Agency and the Alcoholic

A positive, unbiased attitude on the part of the agency board and administration can very readily influence the amount of time, money and skill that may be invested in the treatment of the alcoholic. The community image of the family agency also may influence certain alcoholics' ability to use such treatment. If this image is one of service to the "poor and the weak," the educated, employed family man, who constitutes the largest percentage of our alcoholics, may never be able to get to the agency. Others who are able to do so may find that certain practices make it impossible for him to get the treatment he is seeking. If his alcoholism is identified, he may be fairly routinely or quickly referred to A.A. or a specialized clinic—a perfectly valid procedure in some instances but one which frequently gives the alcoholic a sense of rejection and may build into an often well-established defense that his total problem and his alcoholism are not related.

I think also of practice in which the worker, because of agency policy, may be more identified with services for which a client must show eligibility, than with therapy which focuses on the client's needs, both inner and outer; in which a diagnosis is made of a person's eligibility rather than of the client and in which services end when eligibility ceases rather than when the need is met. Thus we can readily see the importance for family agencies which want to offer a more effective (or more extensive) service to alcoholics to take a thoughtful look at the attitudes, policies and practices which may be actually preventing this client from getting the kind of treatment he needs.

The agency director, depending of course on his degree of interest and concern, would seem to be the key person in a family agency's developing a more effective or more extensive treatment program for the alcoholic. On the one hand, he is in a position to change or modify board attitudes towards alcoholics and, on the other, to make it possible for supervisors and workers to implement the service set up to meet his needs. The director should be aware of, and prepared to cope with, community pressures and criticism as well as to recognize the necessity of selecting particular workers for this service. He must have understanding of this worker's need to have his caseload limited, to have additional supervisory time, particularly until he gains confidence, to have opportunity for special courses which will provide the basic knowledge and understanding of alcoholism, and, lastly, to have appropriate medical and/or psychiatric consultation. Without this, workers will continue to be limited in the number of alcoholics that can be carried as well as in the

extent or depth of treatment possible.

It has become increasingly obvious to those of us who are working full time in this field that not all caseworkers can comfortably and helpfully relate to the alcoholic client. For this reason, it seems wise and valid for agencies to use workers who seem best suited to the task. This will not necessarily be the worker who is keenest to do it (though there must be an interest) for there may be in such a worker some underlying neurotic need, stemming possibly from personal experience with an alcoholic relative. In general, the worker selected should be one who is more mature, personally and professionally, who is sufficiently aware of and in control of her feelings towards drinking and drunkenness so that these will not interfere with her ability to help the alcoholic client. More specifically, those who work best with these individuals need to have a high degree of flexibility, imagination, tolerance and patience. They should be warm and giving persons who are relatively free from overt professionalism and at the same time are able to use limits wisely and thoughtfully. They need to be very aware of and ready to handle the many different and unexpected feelings experienced in the relationship with the alcoholic client.

Selection of Clients

Equally as important as selecting particular personnel to work with alcoholic clients, it seems valid, in the initial stages of setting up a service, not to select those alcoholics who seem less able to use treatment. I think of those (difficult to treat even in the clinic setting or in A.A.) who may be identified by the somewhat vague and unhappy term, psychopath, of those who are psychotic, of those with a severely damaged personality prior to the onset of their drinking, of those whose marriage has never had any stability and for whom meaningful family life has been practically nonexistent, and, lastly, of those cases in which there has been severe damage to the individual and to the family life from long-term drinking.

Some family agencies have indicated that the majority of alcoholics who apply for help fall into these categories. If this is so, it is not difficult to see why workers in general have become discouraged and resistant to treating alcoholics. If the employed family men, the less damaged alcoholics, are not coming to the agency in sufficient numbers for treatment, we might well question how the caseworker is going to gain the experience she needs, not only to overcome some of her negative feelings but to develop some of the same confidence and skill in her work with the alcoholic client that she displays with other clients.

I wonder if there might not already be a nucleus of unidentified alcoholics and potential alcoholics on the caseloads of some family agencies? Other agencies, notably the alcoholism treatment centers, might be involved over a period of time in a plan to screen and to refer a number of reasonably well motivated family men who are not too disorganized. These, in time, if the experience is a satisfying one, will refer others. Beyond this, a well-interpreted change in the agency's attitude toward, and treatment services for, alcoholics might soon be reflected in the community's increasing readiness to refer the alcoholic and in the alcoholic's increased ability to come for help.

Difficulties Encountered

I believe that there are certain difficulties which even the most experienced worker may encounter and which call for considerable support and understanding from the supervisor. I shall highlight three of these:

1. Handling of Fears

Fear of intoxication: A worker may fear personal harm and may also be doubtful of her ability to cope with the alcoholic client when he appears in the waiting room, drunk. She may fear to have him leave knowing he may feel rejected, may harm himself, or be apprehended by the police.

Fear of aggressiveness or hostility: Aggressive or hostile behavior may bring out latent hostility or anxiety in a worker causing her to hit back or to be in conflict over imposing appropriate limits.

Fear of imposing limits: The worker may experience considerable conflict around putting appropriate limits on herself or the client when it seems evident that any imposition of limits may lead to a relapse. This in turn may upset the plans the worker and client have made together, not to speak of the family's somewhat fragile but hard-won equilibrium.

Fear of excessive dependency: This fear may present a threat to the balance of dependence and independence which the worker personally has achieved. The degree of dependency encountered in some alcoholic clients may cause her to overidentify or not identify sufficiently with the client's real needs. She may take on an overprotective, indulgent parental role or respond to his needs with aggression or denial.

Fear of criticism: The worker may experience criticism from the community and colleagues when the alcoholic isn't "cured," when children

are allowed to remain in the home while drinking continues, when agency money is given to a family though the bread winner is still going on benders. Such criticism may deflect a worker from well considered goals, making her feel defensive and isolated.

2. Involving the Client

The alcoholic client may resist coming to the agency even though the family already may be receiving help or, if he comes for some other service, may deny or conceal his drinking. Basic to both is the worker's ability to feel secure in her right to identify the drinking problem with the client, a right which she feels no difficulty in assuming when other intimate aspects of a client's life may be contributing to a family breakdown.

Beyond this there are certain steps the worker can be helped to take directly or indirectly through the wife, which may make it easier for the alcoholic to become involved. I think first of such things as limiting service until he comes, helping the wife to tell him in non-threatening ways of her visit to the agency and of the worker's interest in meeting him, enabling the wife to make some quick change in her behavior or attitude that might seduce or startle him into coming. If these do not work depending on the degree of family crisis, more drastic steps may be taken when the wife is able to do so without too great hostility or need to be punitive—such as court action or temporary separation. If the alcoholic still resists becoming involved in direct treatment, the worker may give indirect treatment through her relationship with the alcoholic's wife. While this may be effective only in relative or limited degree, it may be the only realistic approach.

Whether or not the alcoholic comes to the agency, the worker may begin to focus on other problems but should not for long evade some recognition of the drinking problem. This may be done in some instances fairly routinely in history-taking or through the worker's verbalizing an awareness and an understanding of alcoholism. In some cases recognition of his excessive drinking may come out quite naturally around discussion of debts, marital relationships and recreational interests.

Involving the client, obviously means much more than his getting to the agency, or talking about his problem. It includes motivation, the degree and quality of it as well as its direction—i.e., he may be motivated towards sobering up, feeling more comfortable, warding off the consequences of his last bout, or toward a problem-solving experience. Often the worker is able to strengthen his motivation to decide on the latter course by a simple repetitious interpretation of the meaning of treatment from the agency's standpoint as well as his own.

3. Understanding What Alcohol Means to the Client

Certain workers find it almost impossible to accept continued drinking and/or relapses after a good relationship has been established and much has been accomplished in the family situation. She may have difficulty in accepting the real significance of alcohol to certain clients, in knowing how deeply a man may fear to give up drinking even as he sincerely wishes to attain sobriety. Relapses may become a threat to the worker's professional reputation and bring a sense of failure if she is overidentifying with sobriety. She may need help in preparing herself as well as the client and the family for relapses and in trying to recognize and understand some of the factors which tend to precipitate them. Even more important is the worker's and/or client's ability to use the experience of a relapse to deepen his understanding of the illness and to work out ways of getting at both the outer and inner factors which precipitate them.

Treatment Interviews

Both the setting and the content of interviews may have a particular significance in the treatment of the alcoholic client. As many clients have strong resistance and fears of the formal interview, it helps considerably if the worker can comfortably and naturally lose some of her more formal ways. I think of something as simple as the worker coming out from behind the desk. One client, a lawyer with a history of a negative mother relationship, expressed the feeling that he felt too much like a small boy coming in for a scolding when the worker kept the desk between them. Interviews in comfortable chairs around a low coffee table in the worker's office enabled him to feel less threatened and more accepted as another professional person, freeing him more quickly to get at his problems. Another client, a woman, mother of one small boy, married to an alcoholic, did very little to handle either her drinking problem or to strengthen her role as a wife and mother until the worker set up weekly sessions in the local snack bar. After nearly a year in which there was considerable progress in both problem areas, she was able to ask for, and more comfortably move into, formal office interviews.

Another adaptation of setting which we might seriously give thought to in our treatment of the

alcoholic client is the long lost art of home visits. I think of the appropriateness of such, particularly to the young alcoholic mother tied down in somewhat inaccessible suburban areas with small children and with no easily available baby sitters or car. Not only might such a setting be realistic, but it might provide the client with the often needed evidence of a worker's reaching out to her. It could also bring a new dimension to the relationship and to the course of treatment as it may enable the worker to gain a deeper awareness of the interaction between family members and of the reality stresses. It might also prove to be a more appropriate, less threatening setting for family interviews.

The interviews, both initial and ongoing ones, call for renewed and deepened awareness of the degree of fear, shame, and conflict that the alcoholic client brings to the experience. The worker must recognize that for some, formal history taking, long since discarded in most agencies, may be a necessary protection and that too little structure may be threatening. The alcoholic, very often is as perceptive and sensitive as a child to the worker's way of meeting him and so needs to gain a quicker sense of her interest and understanding. The worker very quickly, no matter what he says (and alcoholics often set out much more consciously than other clients to shock the worker), must try to give him a feeling of being accepted.

One of the very real dangers in the initial interview is that worker and client may get carried away with the client's often dramatic story to the point where there is little time for the very necessary realistic interpretation of the agency services and for the client to make a choice about continuing. There must also be time for him to express, or for worker to verbalize, some of his doubts as well as his possible post-interview reaction to having told so much about himself. The client needs to gain a sense of what the worker is like and to know something of the way she sees his problem. With a reluctant or resistant client who is not likely to become involved, the worker must guard against coaxing him into continuing in treatment and simply try to leave the door open for him at some future time.

Diagnosis

Many workers who are well able to involve the alcoholic in a relationship tend to lose sight of the need to make a diagnosis of the client, not just of the alcoholism, though it is important to be aware of his patterns of drinking, of the meaning of alcohol to him, of the damage alcohol has done to him, of what satisfying sobriety he has had in the past, or of what growth or change has taken place in periods of sobriety. A diagnosis, as in any case, must include more than this; but very often the worker stops here without gaining any clear picture of his personality development, of significant relationships and experiences (or lack of them) before alcoholism took over. He fails to gain a picture of the inner and outer pressures which may affect treatment in spite of very strong motivation to gain sobriety and a good capacity to relate. Very often diagnosis, if it goes beyond an assessment of the drinking history, may have a tendency to be discarded or lost sight of under the impact of recurring relapses. Not only must workers make an ever-shifting differential diagnosis of the client but, as Miss Perlman points up in her book, *Social Casework,* diagnosis must be more than an intellectual exercise or a means of labeling a client. It must be a "design for action" (Dr. Ewan Cameron—*Theory of Diagnosis*). The caseworker treating alcoholics must have such a design, or she may very readily be caught up in as unprofitable a relationship with the client as is the wife who reacts to and is influenced by the many unusual facts of his behavior or personality. Very easily, the worker may be influenced, not by a planned design, but by unreality, impulsivity and inconsistency as great as the client's own.

The experience of one caseworker might serve to illustrate this: Grant was a married man, nearly 40 years of age, with one child by his wife's former marriage. He was a construction engineer who had just lost his fifth job in two years when he came to the clinic, ostensibly for treatment of his alcoholism, but in reality to get material assistance to meet pressing debts for which he might have to face legal penalties. He was a six-foot tall man, almost overwhelmingly big as well as obese, who had the overtly friendly winning personality of some small boys as well as a high degree of rather shrewd manipulative skill which he had used consistently throughout his life to get his own way. His very aggressive and, at times tearful, noisy belligerent demands to have his needs met seemed to prevent the worker from making anything like a complete diagnosis, certainly not sufficient to make a "design for action." There was, however, plenty of action in the worker's unplanned, sometimes impulsive attempts to stem the incoming tide of some of his infantile demands as well as in her efforts to control his acting out behavior in the clinic, the home, and the community. All such

action produced only superficial growth, and at the end of nine months he left of his own accord with none of his problems really worked on.

Relationships

The individual relationship with the alcoholic client is no different in essence than the one a worker may have with any other client except in the somewhat excessive degree of most of its elements. For example, there are above all, more feelings involved in it, for both worker and client; there is greater demand made on the worker to give acceptance and support and on the client to give up the one thing that may have held him together over the past few years. There is need for more conscious awareness in the worker's use of basic casework skills and principles. The intoxication, excessive dependency and other manifestations of an alcoholic's illness may cause the worker to lose sight of "respect for the individual," his right to "self-determination" and the "need to start treatment when he is ready."

The worker experiences more testing by the client and the client may have to accept stricter limits than in any previous relationship. Frequently, so many limits must be imposed that the client may have difficulty in believing that the worker is really on his side. Among the many roles the worker may be called upon to play in treating the alcoholic client, the teaching role, often denied by caseworkers, takes on special significance. I am reminded of the many alcoholics who literally do not know how to use the time they find available once their drinking has stopped. I think of the J. family in which the alcoholic father was the very capable president of an internationally known company, but, almost literally, neither he nor his wife knew how to go about developing satisfying hobbies or interests for themselves or their children.

Because of the alcoholic client's tendency to have a very unreal approach to problems, the worker may have greater difficulty to keep the focus on reality. The conflict between risking a relapse and maintaining the status quo makes it more difficult for the worker to keep the relationship one in which there is challenge and opportunity for growth. Both client and worker may be faced more constantly with a sense of failure. There will be need for considerable support from the worker, but she must guard against over-identifying with his disappointment. At such points the worker should accept as part of the illness the client's need to break from treatment for varying periods of time (sometimes months), picking up on his return from where they left off.

Goals

Many facets of the alcoholic client's personality may make goal-setting and goal-achieving a somewhat more hazardous and more frustrating experience than it is with many other clients. His overall sense of failure around the control of his drinking often makes it harder for him to feel that he can achieve in other areas of his life. By the same token real success, such as he may have in business, may often deter him from trying to achieve goals in relation to his drinking. The impulsivity so evident and persistent in many alcoholic clients leaves little room for thoughtful planning. Difficulty in sticking with problems (or interests) or in concentrating for long periods often makes certain alcoholics give up readily. In the very characteristic inconsistency of the alcoholic client the goals made one day may be discarded the next for no obvious reason.

In spite of the very direct relationship of the alcoholic's personality to his treatment, all too often the first goal he and the worker may set up is that of total sobriety or some other equally long-term goal. Obviously there must be some such goals, but the alcoholic, more than the average client, may need to experience initially or possibly over a long period in the relationship, a series of quickly achieved, limited goals. These may be related to the control of his drinking (the A.A. "one day at a time") or to other areas of his life (learning to handle the simple problems of everyday living). While the alcoholic client may have an unusual sense of failure which makes such goals more necessary, the worker must be very consciously aware that many such clients cannot readily tolerate success.

Not only does the alcoholic client bring more difficulties and frustrations to this aspect of treatment, but the worker's own inability to accept realistic and limited goals often provides equal difficulties. So great may be the alcoholic's identification with failure, so limited his satisfying experience with success or achievement in the everyday business of living, that the worker may need to identify even such simple goal achievements as getting to the first interview. The worker may need to talk to the client in terms of working together for three weeks even though he is aware no real problem-solving will take place in this space of time. Only after these short-term goals have been achieved with sufficient success to offset the many failures, should a worker set up more involved or long-term goals. The worker's very

recognition of the alcoholic's latent potential may often cause her to have too high expectations for the client which does not take into realistic account the presence of limiting factors within his personality. Often the most difficult though realistic goal for both worker and alcoholic client may be to slowly face the many implications of his illness, while enabling him to find increasing satisfactions in life.

Referrals

There would seem to be some evidence that many alcoholic clients on family agency caseloads may break from treatment at a point where a referral is made to another or additional source of help. For this reason it seems important to consider briefly the special significance of referral to both client and worker. It seems obvious to say referral is more than just being sent to a source of help, but many times this is what it appears to be to the alcoholic client unless he is adequately prepared and supported. No matter how real the need may be for the referral, the client may feel it is a rejection for something he has done to the worker (and it may well be), or he feels he is being sent away from the one person who cares before he is ready to test himself in another relationship.

In this kind of case, in contrast to referral of other clients, the worker may need to give considerable verbalization of the alcoholic's fears, greater interpretation of what may be expected (sometimes role-playing of the actual experience may be called for), repetitious reassurance of the necessity for the referral as well as of her continuing to be "with him" through it all. The worker is called upon much more than she is with other clients to work with those in other disciplines (or agencies) much as the members of a clinic team work together, each playing a significant part in his rehabilitation. This means the worker must lose any sense of possessiveness she may have in regard to the client, must learn to handle any feelings of being threatened by the skills of other disciplines and try to gain a deeper awareness of their particular contribution to the treatment. She must free the alcoholic client to use the help of other disciplines, appropriately accept a degree of overlapping and yet be aware of, and put limits on, the client's effort to play one against the other.

Group Treatment

Casework treatment of the alcoholic in a family agency need not be limited to the one-to-one relationship. I would like to suggest the possibility of family agencies making more extensive use of casework treatment to certain alcoholic clients (and/or wives) in a group. Many alcoholics, as evidenced by the A.A. program, can relate best within the safety of the group. Others have a fear and resistance to the individual relationship but are readily able to use help in the group. This is not only a valid method of reaching certain alcoholic clients but may be an expedient way for the family agency with limited staff to treat these particular clients.

In group counseling the caseworker brings to the group the same warmth, understanding, tolerance and acceptance she brings to the individual relationship. She can make the same sensitive, imaginative use of her casework skills and principles. The goals as in any casework are directed toward problem-solving and at the same time the client may experience the give-and-take of social relationships, may gain greater understanding of self and of others. The group leader (the caseworker) uses herself as in any professional relationship in a variety of ways. She may stimulate and challenge the members to share experiences and feelings and to evaluate one another's points of view. She may keep the group focused not just on particular problems, but on themselves in relation to the problems. The worker needs to be more active than in formal group therapy in keeping limits, encouraging the members to participate and to react to other member's behavior. In the initial stages and at appropriate times a limited amount of didactic material may be interjected on such concepts as dependency, rejection, hostility, self-discipline, limits, and last but not least, on alcoholism.

Conclusion

Alcoholism is increasing at every level of our society in rapid strides. While no major research has been done to show us what effect this is having on family life, every thoughtful caseworker has evidence that it can bring involved suffering and sometimes permanent damage even to the strongest family and may destroy those families which might have held together in the face of other difficulties had there not been the additional problem of alcoholism. Ten years of experience in family-orientated casework with alcoholic clients leads me to believe that casework treatment of the alcoholic client may be as effective and satisfying as the treatment of any other client and that family agencies can and should play an important role in the treatment of alcoholics.

NOTES

BY JEAN V. SAPIR, M. A., M. S. S.

Relationship Factors in the Treatment o

Certain procedures and techniques appropriate to work with alcoholics have been developed over a number of years in the clinics of the Connecticut Commission on Alcoholism. The writer's experience has been in the New Haven clinic, the staff of which consists of a psychiatrist, a physician, and a psychologist (all part-time), and two full-time psychiatric social workers. This clinic is one of five similar clinics throughout the state, all of which are served by a fifty-bed hospital for alcoholics in Hartford. Men and women are seen in about the proportion of five to one, and eight of the hospital beds are reserved for women patients. The social workers take referrals, see patients or relatives initially, but arrange for contact in intake, when indicated, with other professional staff.

The techniques developed in the clinic, particularly those directed toward the consolidation of the early contacts into usable treatment relationships, may be of interest to social workers generally, not only because of their interest in this particular group of patients, but also because these techniques may be useful in working with other clients or patients. Many other individuals have characteristic reaction patterns similar to those of the alcoholic. Like him, they can be described as "impulse neurotics." They get into difficulties through acting out their impulses to steal, to assault, to "have a good time" (at any cost), and above all to run away. Such persons present many of the same difficulties in establishing relationships. They comprise a group of persons who seem unable to use casework help. We have found that overindulgence in alcohol is seldom the only manifestation of impulsive behavior in the lives of our patients. Although it may be a prime factor in the creation of social difficulties, it is only one factor in the sum total of the personality disturbance. The techniques that are effective in helping persons who drink uncontrollably on impulse may be helpful in dealing with others whose impulsive behavior is socially wasteful or destructive.

The key feature of our approach has been to respond quickly and decisively to the needs of our patients in the initial application for help. It is out of this situation of "asking and receiving," where something tangible or intangible is given, that communion on a feeling level is established. If this communion can be established, it provides a favorable beginning to the development of the treatment relationship; without it nothing of any significance can happen.

In service agencies, individuals who come with problems of considerable stress and fail to follow through with planning unless their requests are met immediately on their own terms, are apt to be "weeded out." But they continue to turn up with their requests at agency after agency, and they go on making plans for themselves of one sort or another, without guidance. The result is that they get into deeper difficulty which in the end must be handled by society in one form or another, and often at great cost. An approach along the lines we have found workable may open up new avenues of service to these persons.

In the earlier days of social casework practice, before the considerations implicit in arriving at a social and psychiatric diagnosis were so clearly

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he Alcoholic

Editor's Note: Eleven years after the original publication of this article, the author was asked to comment on the following excerpted passage: ". . . the rehabilitation effort at all times should be focused upon the patient himself." This is what she had to say by letter in September of 1964: "It (the passage) represents the keynote of my belief and practice re: work in clinics for alcoholics. In other services, of course, a social worker would work from whatever angle most naturally presented itself. For instance, in a service for adolescents, the social worker would help his young client clarify his feelings and attitudes towards the alcoholic parent in the light of his broader knowledge of the problem. Should the client be able to lead the social worker into significant contact with either the alcoholic or his spouse, he would include them and hopefully achieve a broadly based family therapy."

recognized, many workers established such communications with their clients by "intuition." But in later years the burden of applying difficult technical concepts has acted as a restriction to normal response to the feeling of the clients. Caseworkers, particularly the young ones, now dare not allow themselves to respond "on impulse" and, as a result, often lose their clients while trying to make up their minds about what they should or should not do. Among the clients thus lost are those whose disturbances stem from impulse neurosis. In their case, the only approach that seems to have value is one that includes a frank meeting, in so far as possible, of presenting needs. This should be utilized as a planned approach for clients who are endeavoring to "run away," literally or figuratively, in one way or another; it is the only one to which they can respond.

In the early days of casework development, such direct help was often given without much awareness of the psychological implications of giving and receiving. As a result, the workers at times became overinvolved in the lives of their clients. In reaction to this danger, various safeguards against such involvement were developed. The many "ifs" and "buts" that had to be considered before embarking on a treatment plan served as an automatic check to spontaneity. The easy give and take in interviewing was blocked, with the result that clients who could not participate in a process of planning felt chilled and rejected. The failure to meet their emotional as well as their material needs resulted in withdrawal from contact. The client would perhaps take his application elsewhere in search of at least a "feeling" response, often to a matron at the jail, the man across the bar in a saloon, or to any of a hundred sources of untrained assistance. But what such clients really need is acceptably offered trained assistance. The technical question is how to give this help to disturbed people constructively, responding to them warmly and spontaneously, without becoming too involved in their problems. We must learn to be able to trust our intuitive responses in all intake situations, including those involving individuals who "can't wait" for solutions. These persons need the affirmation of the worker's interest—and the affirmation of his warmth—at once. They can respond to a warm emotional contact with a particular person; they must feel this warmth before they can enter into what we call a casework relationship.

Consolidating the Relationship

The diffusion of the difficulty in alcoholics, which involves physical torment (one big headache), is characteristic of the new patient on his first entry into the clinic. The physician-caseworker team, by handling realistically the emergency problems presented, can offer an effective initial response to the addictive drinker's conflicted "cry for help." His motivation for crossing our threshold is usually a gun at his back in the form of real disaster—social, physical, or mental. Building up a creative rapport between the clinic and this conflicted, fearful, evasive, and above all, tentative new patient is possible only if there is clear recognition of the real crisis in his affairs which brings him to us. Understanding the deeper aspects of his individual problem will at first be a secondary consideration. Help must be extended toward getting him out of his immediate predica-

ment so that he will be motivated to continue contact. Necessary as it will be eventually to treat him like any other medical-psychiatric patient—with regulation of satisfactions and frustrations in the therapist-patient relationship—this approach must be held in reserve during the initial stages of the contact. Because of the nature and urgency of his specific needs, his needs must be met in some measure in these first contacts.

When an alcoholic comes to a clinic, it is because he thinks the clinic can do something, usually in regard to the predicament his drinking has created. This urgent need usually takes precedence in his mind over the implicit purpose of his coming —treatment of his addictive drinking. It is important that we help him understand that we are aware of his conflict about giving up alcohol—or even seeing it as a problem—and of his wish to utilize contact with us for secondary gains. Some of these secondary gains we should accept as legitimate needs. We should, for instance, be willing, at his request, to tell his employer that he has applied to the clinic for treatment, thus winning for him "another chance" on his job, but we should have no hesitation in discussing with him what he will have to accomplish to make good on this "chance" now that he has it. The alcoholic often attempts to use the clinic for no other reason than to impress someone that he is "doing something" about his drinking. Even when his expressed wish for help is genuine, he will attempt, in his drive to maintain the satisfactions of drinking, to engage his therapist in the intellectual game of searching for "causes" behind his addiction, using this device to sabotage therapeutic efforts to have him face, and do something about, his current drinking.

The caseworker at intake has two tasks to perform simultaneously. He must be working out some sort of a rough social diagnosis of the presenting situation, at least to the extent of deciding on whether or not an emergency exists that calls for special psychiatric or medical handling in intake itself. At the same time, the caseworker must be moving to initiate the clinic's treatment program, using sound therapeutic techniques but manipulating them with special reference both to the known personality characteristics of the alcoholic, and to the pressures that brought the patient to the clinic. Certain basic needs must be met in some small measure from the beginning of contact if real treatment is to get started.

Special Characteristics

The alcoholic's impulsiveness, his inability to stand frustration of impulse, and his inability to tolerate pain, must be taken into account in the early contacts. This characteristic indicates the advisability of seeing him as soon as possible—today, tomorrow, or the next working day at the latest. He may be seen at the clinic, or if this is not possible because of his condition, his family or friends can be helped to work out arrangements for his admission to a hospital or a rest home through a private doctor. This immediate response is similar to Alcoholics Anonymous' all-out response to the first call for help. It points up the need for flexibility of schedules and the possibility of "squeezing in" new patients when necessary. Just as the alcoholic will come in "on impulse" so, of course, he will break appointments, also on impulse, thus leaving time open for the meeting of emergency intakes and services to returning patients. Because considerable time is required to enable such a patient to settle down to regular appointments, flexible reception and intake procedures are essential.

The immediate relief of physical distress is of great importance. In all his welter of fear, resistance, and physical pain some relief of distress is not only a boon but constitutes a tangible proof that we want to help him. If we can accept as natural the emotional distress he feels about having to come to us, it will often minimize his impulse to act out and to run away before we get to know him. We should also be prepared to meet fears about his mental status and possible need for commitment. His total attitude might be summed up as "What have I let myself in for?" He fears the possible loss of his independence and the threatened loss of his source of pleasure and escape route by means of alcohol. This patient, when we first meet him, is in balance between contrary impulses—one to come and work with us on his drinking problem, and the other to preserve at all cost his independence and his drinking. His impulse to work with us—to achieve total and permanent abstinence from alcohol—is often not only opposed by the desire for satisfactions through uncontrolled drinking, but by the hope that our treatment will enable him to drink in a controlled way, and not have to surrender to the reality of abstinence. At intake, and in our early contacts, we have the opportunity to tip the balance in the direction of sobriety, by giving him some urgently needed satisfaction of basic emotional needs. Providing physical care and working with him on his social predicament can often provide sufficient help so that his need to drink can for the moment be controlled. This, in turn, can

win back for him some measure of support from important figures in his environment whom he has antagonized through his drinking, thus reducing to manageable proportions his dependence on the clinic.

It is important also to foster the patient's "transference" to the clinic as a whole. His low threshold of pain—physical, social, emotional—creates the need for various sources of support and help. According to his need of the moment he should be in easy contact with doctor, caseworker, and psychiatrist. The freedom of contacts is particularly necessary in the intake situation, but is also important during the continuing contact, regardless of which member of the team has the chief treatment relationship.

The alcoholic's extraordinary dependence on other people for his evaluation of himself is another characteristic that must be considered in working with him. He has been scolded, scorned, and punished by family, friends, and employers, and is often in conflict with legal authorities. His concept of himself is a mirrored image of these attitudes. His estimate of himself is low, whether he actually appears meek and ashamed, or is defiant of everything and everybody. The first objective at intake is to treat him as a man—or a woman—who is "deserving" of interest.

Prompt and courteous handling of him in our waiting room does much to establish this attitude, particularly when he is disheveled and dirty, as well as drunk or suffering from a hangover.

Focusing our first interview on a frank discussion of his drinking problem and showing awareness of the inevitable social predicament to which it has led are usually sound procedures. The focus on his complaint, as in any other clinic situation, helps to turn him away from his preoccupation with "What are they thinking about me?" Interest in what has been happening to him together with the relief of physical and social distress constitute important steps in building up his depleted reservoir of self-esteem. This approach can restore some measure of his ability to think and act on his own behalf as a self-directing person. Because we show that he is "worth the trouble" he is causing us, he comes to believe again in his own worth.

The alcoholic's extraordinary need for a supply of love, not only to bolster his self-esteem, but to enable him even to function, must also be taken into account in working with him. To be able to keep this patient in treatment, we must make him feel he is "getting" more than he is giving. The technical problem is how to make the giving constructive. The first principle is that we must be able to accept, emotionally, extreme dependence. We encounter in him various stages of helplessness, particularly in the hangover period. Accompanying the dependency, however, is an equally strong opposite of independence, which we may have to handle in the course of the next day or two, as the patient tests out this newfound relationship. In his dependent swings, the patient may have fantastic expectations of what should be given to him; when these are not fulfilled, his hostile reactions will be proportionately irrational. We must also be ready to accept emotionally these swings as they appear. Throughout, we must continue to gear our practical services to reality needs, but measured in the light of the physical and emotional status of the patient at the moment. This status varies greatly from time to time.

In early contacts, we should restrict history-taking to the necessary minimum, so that the patient will have no reason to feel that we have asked him to give more by way of information than he has received in help. We may even have to help him, if he is drunk or has a hangover, to curb his urge to pour out information which he may later regret having given us. Most important, perhaps, is that we face squarely the "price" that the patient is paying for the service; he is being asked to give up the tremendous satisfactions of his addiction. If he abstains from alcohol, he is giving the therapist a great reward—he gives up what has been primarily a pleasure.

In psychiatric treatment of neurotics who are not addicts, the giving up of pleasures is also necessary, but it is not demanded in the clear and uncompromising way that it is with alcoholics. The very nature of addiction itself means that the patient feels, at least "underneath," that he is being required to make a sacrifice. Considered from a practical point of view this feeling is valid. When a clinic patient, whose drinking has made it necessary for society to support his family or finance expensive medical care, gives up his drinking and takes over his own responsibilities, he is relieving society—and the therapist who represents society—of a great burden.

Special Transference Problems

One difficulty many therapists experience in working with alcoholics is accepting the many falsifications that the patients present. They tend to distort truth and tell outright lies, especially during early contacts. In certain situations, particularly where his drinking is involved, the alco-

holic, like the child, acts as though he believes in the magical power of wishes and thoughts. He hopes, it would seem, by expressing his wishes as facts, to bring about results of various kinds—to minimize the consequences of or divert blame from his actions. Coming for help often has meant choosing the least of several evils; the alternatives may be losing his wife, his home, or his job, or going to jail. His degree of stress leads him to hope that we somehow can "make magic" and improve his situation. He, in turn, calls upon whatever magic formula he found effective in the past to evoke a desired action-response from power figures in his environment. He now utilizes these mechanisms, trying to entertain us, horrify us, or dazzle us, in order to evoke pity, interest, and concern, so that we shall protect him as a parent protects an infant. He may camouflage the most obvious facts, attempting to hide unacceptable truths from himself and from us. If we are not able to accept these defensive tactics, recognizing them as natural in a sick person, he will sense our withdrawal of trust and, as a consequence, his own participation in treatment will deteriorate. He will not only feel censured and guilty again, but weak and unloved. His magic has failed its purpose of obtaining love. Obviously, it is necessary to be clear about the "facts" of a situation; but the emotional "facts" should be a major concern. The way a patient "makes magic" can tell us much about his emotional needs and development.

The lack of clear motivation for treatment on the part of the alcoholic when he first comes for help is disturbing to most therapists when they begin working in this field. They comment upon his "lack of sincerity." As has been indicated earlier, contact, at the beginning, is often a matter of touch and go. Many persons have not faced the reality that they need to stop drinking, or that they need help in becoming abstinent. They go through the motion of asking for help because it is the politic thing to do at the time but they still continue to discount the seriousness of their problem. Our experience has shown that many who first come to the clinic to placate other people will return later on to work on their problems—if we ourselves have been able to face and accept their true state of mind when we first see them. We should use the opportunity in these first contacts to explain about the service, so that the patient will know what it involves should he decide to come back. Often it will be months before he returns, but when he does we frequently find him ready to begin work with us. In the interval, he has done some additional thinking about the problems discussed in the first contact or in reaction to new breakdowns in his social situation due to his drinking. It may only be when a patient returns for the fifth time in as many years that he is ready to settle down to serious work on his problem.

A particular difficulty in working with alcoholics should be noted. It is often difficult for therapists to keep on working with patients who gain obvious pleasure through their illness. Often, after a good relationship has been established and the alcoholic makes marked improvement to the satisfaction of both therapist and patient, he suddenly goes off on a roaring spree, recklessly spending his own and his wife's savings, and perhaps wrecking the family car into the bargain. He sheds responsibilities that the rest of us cannot let ourselves escape. It is only natural for us to feel some resentment. It is true that the alcoholic will suffer acutely from the effects of his spree; hangovers, both physical and psychological, and undoubtedly painful. But this suffering may seem minor to us in relation to the sufferings he has created for others, and it may not loom very large against our own sense of frustrated efforts in the therapy situation.

We must mention, finally, a not uncommon problem for therapists seeing alcoholics exclusively. A kind of overidentification, not so much with individual patients, but with the group as a whole, often develops. We sometimes hear alcoholics being spoken of as "wonderful guys" when they are sober, and when these "wonderful guys" are getting over their sprees, we may hear needlessly lurid tales of their exploits.

Needless to say, either one of the above attitudes is as limited to true therapy as the other. It is as dangerous to underidentify as it is to overidentify with our patients. It is indeed difficult to keep an even balance of feeling when we work with patients who are constantly acting out opposite trends of feeling!

Role of the Social Worker

A few brief comments should be made about the caseworker's part in the subsequent treatment of the patient in our clinic. Only a few of the patients are able to utilize intensive "uncovering" therapy. Their main need is for understanding and support through a period while they are attempting to reorganize their lives on a non-drinking basis. Often, such supportive treatment can be undertaken as well by a caseworker as by a psychiatrist. If the caseworker is

a woman and the psychiatrist a man, she may do better because of this fact alone. Because the basic difficulties that lead to alcoholism generally stem from disturbances in the earliest phase of the mother-child relationship, the handling of these patients by a woman may be particularly effective. This is equally true with men and women patients. Further, acceptance by a social worker is especially meaningful because the worker represents the interests of the family and of society—it is to a social agency that the spouse goes for help with problems created by the drinking. Such acceptance may be an important factor in promoting progress toward the therapeutic goal of helping a patient put his past behind him and make a fresh start.

Relationship Factors in Treatment

The supportive procedures with the alcoholic are much the same as with any other patient; developing a positive relationship is basic. The relationship should be built up through well-timed and appropriate practical help given at intake. The aim of the caseworker is to encourage the patient to tackle various problems as they present themselves in the course of his attempt to work out a way of life based on sobriety. Personal problems of feelings, attitudes, and behavior will come up quite spontaneously for discussion in such an atmosphere, even some that the patient has not allowed himself to think about in the past. Episodes of renewed drinking will yield additional information about the nature of inner pressures. In the hangover period the patient often expresses his concern over the unacceptable feelings he expressed or acted out under intoxication. Within the supporting relationship, it is possible to help him develop some understanding of legitimate needs that he had endeavored to meet through drinking, and to discuss socially acceptable outlets or means of gratification that are available. Although the patient will need to see others for medical care at such a time, he generally wishes to return to the social worker to whom he had been talking before his "slip." Picking up on the relapses is often a most fruitful opportunity for advancing the treatment. Unless the anxieties he expresses are handled constructively then and there, treatment will suffer; not only will an opportunity be missed to help the patient understand himself, but a weakening of the relationship itself may result. The patient will sense the avoidance on the part of the worker and will interpret it in terms of his own pathology.

One special point that should be emphasized is that the rehabilitation effort at all times should be focused upon the patient himself. The therapist is sometimes tempted away from this focus, particularly if the spouse is eager to have appointments and the patient is not, or if the social problems of the family as a whole are urgently in need of attention. If the therapist permits himself to be diverted in this way, he creates for the alcoholic a repetition of the experiences he had with agencies in the past. It, therefore, lessens or even obliterates the slender chance there is of helping him. In many instances it is the "delinquencies" of the alcoholic husband in matters of support and rearing of the children that bring the wife to a social agency. As a result he leaves the management of these contacts to his wife and, in many cases, comes to think of these problems as "hers." When a husband, therefore, does reach a treatment resource, he should be made to feel the contact is "his." The extent to which other members of the family are to share in it deserves most careful attention and planning.

A clinic for alcoholics cannot operate in a community without social work resources; it will be dependent on other agencies for supplementary and collaborative work both on the problems of the patients themselves and on the problems of their families. A person who comes to the special clinic for consultation on the drinking problem of a spouse or a close relative who is refusing treatment would naturally be referred to an appropriate community agency for help with family problems. Similarly, there will be situations where it will be advisable for the clinic to refer the families of patients to other resources for treatment while the clinic devotes itself exclusively to work with the addictive drinker.

The alcoholic has a special need to feel he is understood and accepted as an individual. That he has reason to feel this goes without saying; society still views him more as a delinquent than as a sick person. Patients frequently say, referring to Alcoholics Anonymous, "It is only those who have been through it themselves who can understand, and can give effective help." Sometimes they add "or at a place like this where you see so much of it." Because of his character structure, the alcoholic does feel "special" and has an urgent need to be treated as "special." The approach to these patients, like all treatment endeavors, should take into account their individual needs, even though these may be more excessive than those of some other groups.

The Female Alcoholic

BY NICHOLAS E. STRATAS, M. D.

Very little has been written on the female alcoholic and perhaps quite rightly so, for one may well ask whether the female alcoholic is any different from the male alcoholic. There has been some work published especially having to do with the epidemiology and sociology of the alcoholic problem in women but little having to do with the management and treatment of the female alcoholic. There are impressions, usually based on subjective observation, which seem to indicate that alcoholism is on the increase among women. They are extremely difficult to evaluate, however, and even current statistical figures are somewhat skewed as one finds when one begins to work with female alcoholics that there is a great deal of hidden alcoholism among women.

Marked inroads have been made on changing the moralistic attitude towards the male alcoholic and we find now that the male is increasingly recognized as an emotionally disturbed individual. However, the attitude towards the female with an alcoholic problem continues to be quite moralistic since it commonly represents the breaking of stronger taboos. Drinking and intoxication in women runs quite counter to the idealized "ladylike" behavior. Even in terms of social drinking, we find a double standard which is somewhat permissive with males and yet continues to frown on drinking in females.

When one looks at a group of female alcoholics, there is found the usual mixture of various underlying personality structures that is found in male alcoholics. Looking closer however, two groups stand out which bear commenting upon.

One group of alcoholic females seem to be those that started their drinking at an early age, problems have shown up earlier, and they seem to have problems in multiple areas of sound interaction. Although this is the group who usually make up the skid-row type element of the female alcoholic, by no means does the lower socio-economic group supply the only source of this type of patient. This same type of person is seen coming from middle and upper classes although perhaps not in relatively the same proportions.

The other group is made up of those females who seem to present their problem later in life, in their 30's to 50's. Their problem with drinking is one of recent history and there seems to have been a relatively good adjustment to the life situation beforehand. Conversely to the first group, a large proportion of this second group does come from the middle and upper socio-economic classes and we do find a relatively smaller proportion of this group coming from the lower socio-economic classes.

Interestingly enough, as one takes a closer look at these two groups, predominant personality patterns emerge unique to each group about which we may generalize, remembering that there are many individual differences. In the group which starts drinking earlier and is having general problems in living, we find a preponderance of personality problem disturbances of a rather well ingrained nature with alcoholism being but one of many pathologic defenses. In general, the personality makeup is one of a passive dependent hostile nature with what has been called a "swiss-cheese" super ego. These people generally have extremely intense feelings of inadequacy which go hand in hand with their unusual dependency needs and cause a great deal of anxiety in the patient as these feelings conflict with strong wishes for ommipotence or perfection and independence. The alcohol is utilized in an effort to resolve, or, better stated perhaps, dissolve the anxiety while at the same time it serves as a mechanism for communicating the hostile feelings. Obviously the weakness in this mode of handling feelings of anxiety and hostility is that it provokes feelings of guilt about the drinking, not only because it is not socially acceptable but also because it incurs remorse about expressing anger in this fashion. Interdigitating with this, then, is the inherent quality of our society which demands that the guilty be punished. This group then moves to be punished and where they are not punished, it is not unusual to see them presenting themselves to the authority and confessing their behavior and in effect, requesting punishment. By simply confessing the unacceptable behavior, they have inflicted a form of self-punishment. This punishment only serves to reinforce the feeling that this person has always had that "since I have been punished, it proves that I must be inadequate" and so adds fuel to the feelings of inadequacy and engenders further anxiety and anger for having been "made to feel inferior." Because of the nature of their personality these patients have also been giving vent to their feelings of anxiety and hostility in other socially unacceptable maneuvers and consequently

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Nicholas E. Stratas, M.D., on request, wrote "The Female Alcoholic" especially for this manual. A psychiatrist, Dr. Stratas is director of professional education and training, North Carolina Department of Mental Health.

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have had stormy relationships with their parents, have been unable to achieve satisfactory marital situations, and have often times been at conflict with the law.

The group of female alcoholics whose alcoholism developed later in life are somewhat more difficult to talk about in general terms, but still present certain prominent characteristics. In this group, we more often find a more obvious related life situation which can be connected to the drinking. Although these people also show the same elements of passive dependency, it is not such a pathological pattern and in fact we find that these people have been able to sublimate a great deal of their anxiety and hostility and do have a relative sense of adequacy. Probably the standout feature with this group is the actual overt anxiety they display whether it be in terms of free-floating anxiety or depression. Women in this group usually give a history which indicates marginal or even fair social adjustment, acceptance by their peers, and fairly good interpersonal relationships prior to the onset of anxiety and drinking.

Although outlining two apparently distinct groups, it is important to note that these groups are not distinctly different but rather are at different ends of a common spectrum. On the one hand, the second group has established the ability to be involved in warmer relationships but requires reinforcement and supplementation by their marital partner or other such meaningful person, while on the other hand, the first group has learned less about establishing warm relationships and being involved in the give and take of every day life. This, then, makes the first group much more prone at a much earlier period in life to succumbing to stresses which may not even seem unusual. The second group seems to get along for a longer period of time until some of the reinforcing and supplementing relationships are removed at which time they are unable to navigate alone. In terms of the treatment of the female alcoholic, it is important to evaluate each individual case to ascertain where along this gradient the patient falls, since this has a great deal to do with prognosis and the type of program that will be planned for the patient.

Early in management where the patient has been in a program to take care of her acute alcoholic or post-alcoholic status, the remorse of the first group and the anxiety of the second group must be capitalized upon and utilized to begin to re-educate the patient and to offer her avenues for acquiring insight. By "avenues for acquiring

insight," I am not referring to the traditional type of individual psychiatric approach, although this may be a part of it, but rather, through group situations and the milieu, insight into daily life patterns and insight as to methods of dealing with one's anxiety and hostility in new and constructive ways.

The "psychotherapy" of the alcoholic female must be conceived in the broadest terms and must involve an active therapist who is willing to accept, educate, re-educate, interpret to, exemplify for, visit, and interact with the patient. Although analysis is recommended as the "treatment of choice" by many, we can only assume that anyone prescribing this method has not worked with alcoholics. I do not mean to imply that the analytic concepts are to be ignored because our understanding of the patient in dynamic terms is essential in creating a meaningful treatment program, although as we all know many profitable programs give no consideration to analytic concepts. Therefore, there must be an evaluation of the social situation, not only to ascertain the pathology but, very important, to determine and utilize whatever potential buttressing, reinforcing and supporting elements that may be in the home and community situation. With the second group of alcoholics, we generally find that there are more resources available, mainly because this person has established meaningful relationships in the past that can be brought to bear again. On the other hand, with the first group of patients, resources are not only minimal but oftentimes are negative in the effect they have on the patient and may cause the therapist to look to another social situation for helping the patient establish meaningful relationships.

It is important to recognize the fact that the problem of dependancy is aggravated by the traditionally dependent role of the female in our society. This is further aggravated when one considers the fact that the female role has evolved over the past many years to include a more aggressive independent flavor. Thus on the one hand, there is the emphasis that the female should be dependent, while on the other hand, the evolution of the feminine role makes this dependent relationship undesirable. Thus we must have an anamnesis which will clearly delineate the role that the patient has assumed in her family setting and the role that is expected of her by the family.

utilize a "reaching-out approach" in working with the female alcoholic.

The goal in working with the patient would be to have her accept the fact that there is a certain amount of dependency inherent in interpersonal relations but that this does allow a variable amount of independency as is indicated in each situation. In many situations this involves working closely with the family to help them allow the patient to become more self-sustaining.

With the first group of female alcoholics, those that start drinking earlier and have general patterns of social disorganization evident, an intense long-term program needs to be developed and implemented. It is usually quite insufficient to hospitalize these patients for a short period of time and then to discharge them, hoping that they will somehow get along better. These patients very often do need the initial intense program that residential centers offer; however, they further need evaluation of the home situation and involvement of the family in setting up a structure which will be constructive and therapeutic, or if there is no family or the family cannot be engaged then the searching out of a situation which might be more condusive to a long-term constructive program is very important. The patient needs to have a constant link with the therapeutic facility although the link may simply be weekly social meetings. Generally speaking with this type of alcoholic the meetings and the contact probably should have an anchor with a professional person, although a non-professional might be the continuous contact.

With the second group of alcoholics, those whose alcoholism develops later in life, it is not as often the case that the inpatient unit be utilized at the beginning of the treatment. It is important, however, with this group, to get to the family, since there usually is one and also to ascertain the links that the patient has had in the past in the community and put all of these to work in the therapeutic program. With this type of alcoholic, the long-term program development need not be as structured as with the first group in terms of continuing of professional relationships. This group of people can very often reestablish themselves once the family and community forces have been geared up and made aware of their role in the patient's rehabilitation. Where there has been a loss of an important individual in the network of support that this patient has had, then this means the worker must either help the patient to accept this and extend her efforts in other areas of contact or some other substitute relationship must be worked out. Many times rather than a substitute relationship, some already ongoing relationship may be strengthened to fill the void. With this second group of alcoholics where there is a family structure, we also find that there is tremendous impairment in communications between members of the family and it will be important to insure that there be established a free and open dialogue. Family therapy may be indicated to promote this.

To summarize, alcoholism in females is a complex multifaceted problem with some unique spects. It may merit review at this point to indicate that the worker must feel comfortable with the use of rational, rather than punitive, authority. The worker must be prepared to face a series of crises and be prepared to utilize a "reaching-out approach" which will be tested by the patient over and over again. It seems that these patients can best be reached and helped by concrete and tangible services which rely on building a meaningful relationship but, however, are not satisfactorily dealt with through psychotherapy per se.

It is furthermore important that appropriate family and community resources be utilized. This involves consultation and close cooperation with community agencies to insure that the alcoholic's characteristic impulsiveness and low frustration tolerance do not push her back into her typical patterns of avoidance of help and relapse to alcohol. Furthermore, this is essential to prevent her "getting lost" between agencies.

The action approach appears to be the approach indicated, at least in the initial stages of treatment where we need to communicate with these patients in the midst of continuous acting out. It is also important to keep in mind that the intensity of the relationship needs to be diluted as her inability to tolerate closeness may endanger her already precarious balance.

Finally, the worker must be aware of, and learn to control, negative reactions to the female alcoholic, since this type of patient poses far greater problems than others in unrealistic demands, self-defeating operations, testing the limits of the relationship, and repudiating the social values and standards with which the therapist is identified.

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When the Wife of a

BY JEAN V. SAPIR, M. A., M. S. S.

Alcoholic Comes for Help

How can I get my alcoholic husband (wife, brother, son or daughter) to come for help?" This is a question frequently asked of anyone connected with the Commission on Alcoholism, not excluding the executive director or the attendants on ward service at our hospital. It will have a familiar ring, too, to physicians in private practice, to ministers of religion, to social workers in other settings, to probation and parole officers, and to many other people, professional and non-professional, who are interested in helping people get themselves out of trouble.

In our clinics, most frequently it is the social worker who receives inquiries such as the above, and who attempts to help relatives and others work out the referrals they wish to make. Ask her about her experiences and she might very well respond as follows:

The first thing I think of is a wife who wants help for her husband. She'll hardly give you time to respond before she tells you that he would not be caught dead on your doorstep because he isn't an alcoholic, and that he thinks the trouble the family is in is all due to his wife who is talking to you—she nags or bosses him too much or is a bad manager and drives him to drink, or to seek peace and pleasure away from the home. As the wife talks, her own decorum will almost always break down, for she speaks of something which deeply concerns her. As she recounts her husband's misdeeds, she may express feelings of scorn or fury—he is weak!—he is morally in the wrong! On the other hand, she may want to defend herself against the accusations he makes, indicating that the burden she carries is the conviction that if only she could be different, or act different, she could of herself effect a cure. She may apologize for her own emotional reactions to his behaviors: "I know I shouldn't get after him, but he gets me so aggravated I don't care what I do." Or else: "Perhaps I don't manage very well, but how can I when I don't know what to count on each week? Sometimes he doesn't give me anything." Or again: "But how can I be patient with the children when I'm upset about my husband's drinking?" Or even, "I get angry, I get frightened at myself sometimes, I'm afraid of what I might do, I think he's driving me crazy."

Let us consider for a little the problems involved in helping a wife help her husband to see his need for outside assistance. Obviously, in such cases, we are dealing with someone who is herself in trouble—someone who is angry and anxious, self-blaming and self-defending, and deeply hurt all at the same time. The help she asks for is help in getting her husband to use our service. But before she can utilize any such assistance she must have help in sorting out her own feelings and ideas regarding the problem which is devastating her marriage and the lives of her children, and which has damaged or destroyed the life goals she has clung to up to this point, leaving her in an emotional chaos. If she is ever to be able to help her husband, she will herself need help in focusing her own feelings around new goals, goals possible of attainment or near attainment, within or (if it is inevitable) outside the marriage she has so far struggled to maintain.

The above sounds like a pretty large order. To

fill it properly, you would need the resources of a family agency, or a general psychiatric clinic, as well as your own. Referrals to such sources of help are seldom practical at this stage, however, since it is upon the problem of the alcoholic that the applicant for help is focused, and upon the crisis in family living which his alcoholism has brought about. When such applicants come to us the latter problems are often acute, and we must focus our attention first around the immediate practical problems, though without losing sight of the ultimate aim, to help the alcoholic himself see and feel his need to do something about his problem.

When a person is emotionally upset it is of little use to attempt to give advice about specific action, however soundly based on the facts before you. The only thing you can do is to throw the question back upon the best judgment of the person who asks for it. This may seem cold comfort to someone who faces alternatives such as calling on the police for protection, endangering her own or her children's physical safety, or inviting what to her may be the ignominy of an emergency mental hospital commitment. It does, however, act to recall her to a sense of her own pivotal responsibility for her family's welfare, with the result that she is likely to make a thoughtful rather than an impulsive decision regarding the necessary action. In talking with her we must keep ever in mind that if we can help her feel, as well as see, that her husband is ill when he is drinking, she will find it more natural to accept the fact that it is she who must at this point think and act in the best interest of all concerned, whatever fears she may have regarding his subsequent reactions. When this has been accomplished, she can be further strengthened for what is ahead of her by discussion of ways in which her action at this time of crisis can be used constructively with the alcoholic, once he has become sober and can talk with her. Take, for example, the wife who has had to solicit help from the police when the drunken husband has attacked her and her children. She must take pains to go over with him what actually happened, so that he will be sure to see what peril she felt she was averting, for him as well as for the family, when she called the police. She must be sure not to omit telling him as honestly as she can how she felt when doing what she did, whatever that feeling might be. Such an experience, even though painful to both parties, can act as a "clearing of the air" in a family, making possible a more straightforward facing of unpleasant facts by the spouse

as well as the alcoholic. This alone may give impetus to movement toward the goal we have set.

Throughout a contact such as described above, it is clear that any attempt to give insight to the wife in regard to what you may discern as "her part in the problem" would do harm rather than good. Her feelings are out of control, as it is, and this might in some situations produce a destructive panic. If you are to be of help to her in this situation, moreover, you must not block your own response of sympathy for suffering. Whether she helped bring her trouble on herself or not, she is now admittedly in deep despair. Allowing yourself to feel sympathy does not imply its florid expression, though some expression is both needed and expected. It will only be when the wife feels that you, the helper, have participated in her problem, and responded to her feelings that she can move with you into a realistic discussion of the disorder which has brought her own, and her family's problem: her husband's alcoholism. Our aim here, as stated above, is to help her see and feel this behavior pattern as an illness, despite feeling reactions she has to it in other, quite understandable terms.

Most people who have alcohol problems in their families have read enough of the newspaper and magazine publicity on the subject to be aware that it is regarded as a manifestation of emotional illness of one degree or another. It is not, then, merely a question of presenting this idea itself to the person involved with the alcoholic, though it is well to discuss it in detail, for he may not properly have understood what is meant by the words "emotional illness" and what is implied for its treatment. Clarity here as elsewhere facilitates emotional acceptance—provided, of course, the therapist or counselor himself emotionally accepts alcoholism as an illness. Feeling has impact on feeling in all interpersonal situations, and when feeling is at variance with verbal communications, it is the former which makes the vital impression. In other words, if you yourself do not feel as you speak, your words will have no impact. One might even go further to say that the difficulty many of us have in truly accepting this concept without, in the process, losing sight of the very real social and moral problems involved, is comparable to the difficulty most alcoholics have in accepting the fact that they are victims of an addiction, the elimination of which means permanent abstention from alcohol.

ork with her towards the goal she is declaring—to help her alcoholic husband.

It has been our experience that when we have been able to influence the attitude of the significant relative even a little in the direction of seeing and feeling the alcoholic behavior pattern as a manifestation of illness rather than as "weak," "ornery," or plain "bad," the alcoholic himself will sense a change in the family atmosphere and drop some of his defensive tactics. With a moratorium on scoldings and scornful asides, and a consequent relaxation of general tension, he may find himself feeling friendly enough with his spouse to at least pay an exploratory visit to the clinic—to please her, with the understanding that he's not committing himself to anything. This may get no farther, of course, than moving the scene of the argument on whether or not he has a problem with alcohol to a new setting. But here at least the atmosphere will not be charged with the irrelevant emotion which blocks his thinking at home. And now the clinic gets its opportunity to see what it can do to help him clarify to himself his own true wishes, regarding goals for himself and his family—which will inevitably involve some facing of the meaning of alcohol in his own life and in the lives of those around him.

Such a contact may or may not develop into a true treatment relationship, according to the nature of the patient's total problem and the degree of pressure, both internal and external, he is experiencing currently to find a solution for it. We must work with him from where he is in his own thinking at all times, focusing on the task as described above each time he returns. It has been our experience that eventually many of the patients so seen do finally settle down to work on their problem with us, in the manner best suited to their needs, taking for granted the support we have demonstrated was available for them, and using it constructively.

In almost every piece of literature regarding alcoholism you will find some statement to the effect that unless the patient wishes to recover from his illness nothing can be done for him. This concept can act as a stumbling block in a therapeutic situation, for if the family says he isn't interested in getting help, and he in his early interviews implies the same, the therapist is likely to accept defeat, in effect, before giving any battle whatsoever. So long as the alcoholic actually produces his body for you, in the seat beside your desk, no matter what pressure you know has put him there, you must assume that there is at least the spark of a wish in him to improve his situation. Your business then is with this "spark of a wish," which you must attempt to fan into a flame of recognized desire on the part of the patient to combat the forces making for disorganization within his life. The task of the therapist is most often, then, to elicit the wish to get well and to strengthen it among all the conflicting wishes we recognize as operating in the situation and connected with the maintenance of the illness pattern.

But to return briefly to the wife and her application for assistance: although there will be many cases where it will be possible to help a wife help her alcoholic husband accept contact with a treatment facility in the manner described above, there will be other situations where this will not be possible. Most important of these will be the situations where even a brief survey will reveal an urgent need for a different type of service, either in relation to the problem of the alcoholic, or the problem of the wife and family. Prompt referral elsewhere will then be important, but it will be equally important to give time and thought towards helping the wife understand how to use the suggested resources constructively. A mental hospital commitment, for instance, can be interpreted as a possible beginning step toward rehabilitation, rather than the "end of everything." Referral to the clinic can then become a goal to work towards later on, should the current mental disturbance turn out to be temporary.

There will also be situations where the interviews with the wife will reveal that she has little chance herself of carrying through a referral on a positive basis at the time seen, due to the preponderance of bad feeling between herself and her husband. This situation should be frankly discussed, for in all likelihood it will be possible to find someone towards whom the alcoholic feels positively, and whose good opinion he values, to present the idea of treatment to him with some real chance of success. Otherwise, if he comes, it will be under threat of some sort from his wife, and he may be less ready, on that account, to respond to the clinic's approach. But again nothing can be accomplished unless the wife first is able to feel that you understand her problem, and want to work with her towards the goal she is declaring—to put help within the reach of her alcoholic husband.

The Family Agency's Role in Treating the Wife of an Alcoholic

BY MARGARET B. BAILEY, D. S. W.

Throughout its history, the family service agency has attempted—often without much success—to serve the family of the alcoholic. Because these clients so often terminate their contact prematurely, frustration and pessimism about helping them have come to characterize the attitude of caseworkers in many family agencies. Yet here and there the problem has been tackled thoughtfully, often through the stimulus of one particularly interested staff member. In these instances, study of the literature, review of the alcoholism caseload, discussion in staff meetings, and experimentation with new approaches have combined to produce both hopeful attitudes among the staff and better results with the clients. For example, caseworkers in the Family Service Society of Metropolitan Detroit had been averaging one interview per case with wives of alcoholics. After a period devoted to informal study, discussion, and experimentation, one worker was able to reach an average of seven interviews per case—an increase that at the very least added to the possibilities of helpfulness.[1]

The potential of the caseworker to help the alcoholic family is the subject of this paper. In the course of a research study on the wives of alcoholics, 262 women who were drawn from the caseloads of a variety of community agencies have been interviewed. Extensive contacts have been maintained with members of the Al-Anon Family Groups, a fellowship for relatives of alcoholics associated with Alcoholics Anonymous. The literature of social work and other relevant disciplines has been reviewed, and numerous informal discussions have been conducted with experts in the field of alcoholism.

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Alcoholism Cases in Family Service Agencies

Perhaps as many as 15 or 20 per cent of the applications to family service agencies involve a drinking problem. Usually the nonalcoholic wife is the applicant, and the typical family unit includes her alcoholic husband and their young or adolescent children. The husband rarely seeks help from the agency; in fact, he usually does not seem motivated to seek help from any source at the time of his wife's application.[2] In many instances, the family manifests the outward signs of social stability; the husband is employed, and the marriage has endured for a number of years. The wife complains about her husband's drinking, which, however, she has recognized as a problem for some time and which may at this point be no more acute than usual. The circumstances that precipitate the application often include such threats to family stability as physical abuse, debts, possible loss of job, and concern about children. Some wives are considering separation, others are fearful of losing their husbands.

A smaller number of families represent more severe forms of disorganization. They bring

problems of chronic unemployment and financial dependency, prolonged physical abuse, and severe emotional disturbance to all members, with perhaps a history of admissions to mental hospitals or recurrent separations and reconciliations. In these families the husband's alcoholism is further advanced than in the usual case, in which the wife comes to the agency earlier in the marriage when prospects for family recovery are brighter and more severe damage can still be prevented.

The challenge for the caseworker is to maintain a relationship with the wife long enough to make help possible. The wife's tendency to break off contact prematurely, often after a single interview, is stressed in all the literature on this subject. Margaret Lewis notes that the typical wife, though insistent that something be done to change either the situation or her husband, is herself ambivalent about using help.[3] Laura Askey observes: "The extent of social pathology and the considerable denial of problems and/or projection onto the drinking problem are difficult to deal with." [4]

Concepts About the Alcoholic Marriage

Though these situations certainly are not simple, part of the difficulty may lie in the social worker's conception of alcoholism and the nature of the alcoholic marriage. Basic casework techniques can be applied as successfully to problems of alcoholism as to any other category of social problems, but techniques are, after all, merely the means of attempting to reach the treatment goals.

In early days of family casework, social workers, like almost everyone else, tended to be judgmental in their attitudes toward alcoholics. Alcoholism has been severely stigmatized in our cul-

ture, and most social workers, growing up in that culture, have shared its values. After witnessing the effects of alcoholism in many client families, the early social workers viewed it as the cause of much economic and social pathology. They often failed, however, to recognize the alcoholic as a sick person; they made direct, and usually futile, efforts to stop his drinking; they fell into the trap of regarding the wife as an innocent victim, acted upon by her husband rather than interacting with him.

With the incorporation of psychoanalytic concepts into casework theory, the pendulum swung vigorously in another direction and alcoholism came to be regarded merely as a symptom of underlying psychopathology. That this concept is prevalent in our profession today is evidenced by the findings of a survey conducted in 1959 among members of the New York City Chapter of the National Association of Social Workers. In this study the respondents expressed virtually unanimous agreement (97.4 per cent) with the statement that "alcoholism is a symptom of underlying emotional disturbance," while only about half the sample (49.4 per cent) agreed with the statement that "alcoholism is a disease." [5] Accompanying the concept of alcoholism as a symptom is the related concept that the alcoholic marriage is an expression of the underlying psychopathology of *both* partners. According to this hypothesis, only a woman who requires a weak and dependent husband is attracted to the alcoholic or potential alcoholic. She is able to maintain a semblance of adequacy only at the husband's expense; if he begins to recover from his alcoholism, she will decompensate emotionally.[6] Thelma Whalen has made perhaps the most extreme statement of the symptom hypothesis: "To the skilled counselor, it is clear that alcoholism is merely a red herring which tends to obscure the essence of this marital relationship." [7] In this paper Whalen describes four types of wives of alcoholics commonly found in family service agency cases: Suffering Susan, Controlling Catherine, Wavering Winifred, and Punitive Polly.

Most of us have seen wives of alcoholics who answer to these descriptions, but we are acquainted also with wives of *non*alcoholics who are suffering, controlling, wavering, or punitive. Freudian theories about unconscious drives do not explain adequately why only a small proportion of the women who merit these designations marry alcoholics or potential alcoholics. Furthermore, persons with a wide professional or personal acquaintance among recovered alcoholics and their spouses are aware that some wives are able to accept their husbands' sobriety without marked emotional decompensation. Once the drinking is conquered and adjustments to a sober husband are made, these women seem remarkably like the general population of wives. As Dr. Ruth Fox has stated, there are some alcoholics and their families "whose problems of living are manageable by sobriety alone." [8]

A significant contribution has been made to the recent literature on alcoholism by applying current sociological theories about families under stress. Sociologists tend to reject the concept that the wife's behavior is a manifestation of personal pathology that existed prior to the onset of her husband's alcoholism. Instead, they regard "the behavior of the wife, or the personality traits inferred from this behavior, as a reaction to a cumulative crisis in which the wife experiences progressively more stress." [9] Joan Jackson is the foremost exponent of this point of view. After engaging in participant-observation of an Al-Anon group for several years, she described the following seven stages in family adjustment to alcoholism: attempts to deny the problem, attemps to eliminate the problems, disorganization, attempts to reorganize in spite of the problems, efforts to escape the problems, reorganization of part of the family, and finally, recovery and reorganization of the whole family.[10]

Social workers must use both the psychoanalytic theories and the sociological stress theories, blending them flexibly as appropriate in each case. The strength or weakness of a person's underlying personality influences his response to stress; some persons break down more easily than others. Stress theory, however, provides a useful framework for working with the wife of an alcoholic, regardless of the configuration of her personality. No one who has worked with such a wife will deny that she is seriously upset by the time she arrives at a potential source of help and treatment. The diagnostic question is whether her personality disturbance antedates her husband's alcoholism, and indeed, her marriage, or whether it is at least in part a result of the stresses inherent in living with an active alcoholic. The treatment implications of these two theories are quite different. The first point of view suggests a focus on direct treatment of the wife's underlying problems—an approach that has not been notably successful. If, on the other hand, the wife's disturbance is regarded as even partly a response to stress, the caseworker's efforts will be directed either toward modify-

ing or removing the stress situation or toward enabling the wife to adapt to it with less anxiety and hostility. The wife of an alcoholic often responds favorably to this approach. She becomes able to function more comfortably and may eventually motivate her husband to seek help, so that in a real sense the husband and wife recover together from alcoholism.

Admittedly, the wife whose emotional problems are deep-seated will not respond to this approach. The point to be emphasized is that in the beginning phase of casework it is almost impossible to make an adequate differential diagnosis. Though the worker should certainly be alert to diagnostic clues, he may be more effective initially if he works directly with the stress situation presented and postpones judgment on the degree of underlying disturbance.

Casework Methods with Wives of Alcoholics

Though the wife who appeals to the family agency complains about her husband's drinking, she frequently has no conception of him as a sick person. She may follow her initial complaints with a denial of the full extent of his drinking and its consequences. Many a wife fails to return for a second interview because, as she expresses it, everything quieted down and she wanted to let the situation ride for the present. Often a wife has no understanding that a loss of memory can occur in alcoholic blackouts without a loss of consciousness. She believes her husband must be lying when he says he does not remember his alcoholic behavior of the night before. The husband suffering from alcoholic blackouts may accuse his wife of exaggerating or even fabricating her account of his behavior. A wife may cherish unrealistic hopes that having a baby or buying a new house will make her husband "straighten out," though in actuality adding to his responsibilities often aggravates his drinking. Frequently, she says that of course she would not mind her husband's going out drinking occasionally with his friends, if only he did not drink so often. She may add that if he truly loved her, he would cut down or control his drinking.

Such attitudes may reflect the wife's ignorance about alcoholism rather than the operation of any deep-seated mechanism of denial. Since our society generally has not accepted alcoholism as an illness, the wife, who is a product of the culture, has no particular reason to be any more knowledgeable than the ordinary person confronted with behavior that appears perverse. A genuine effort to help her learn about the addictive nature of alcoholism is worth trying, and, in fact, many a helping relationship has been initiated on this basis. Most professional people who have worked at all extensively with alcoholics or their families have discovered that the early phases of treatment need to include a strong didactic element. A knowledge and understanding of alcoholism should be regarded as a tool that can help free the wife from her constant anxiety and indecision. This view is in accord with Askey's observation: "Developing with the wife of an alcoholic some clarity as to what is involved in the alcoholic's behavior begins to make the situation more understandable and bearable for her." [11]

Rather than minimize the wife's reality problems, the caseworker should offer to help her. The stress of living with an alcoholic *is* painful, and the worker needs to convey his awareness of this fact and his willingness to help the wife deal with the consequences of her husband's illness. The worker who regards alcoholism merely as a "red herring" is not only distorting reality; he is also losing the client and the chance of being helpful. One of the wife's real problems, with which she often needs assistance, is her husband's denial of his illness. Because she too has not viewed his compulsive drinking as an illness, she often pursues frantically such "home remedies" as hiding his liquor, searching for his hidden stock, pouring it down the drain.

Lewis has commented on the paradox of the wife who insists that her husband must change and is equally insistent that he is unwilling to change.[12] These contradictory attitudes need not represent complete denial and projection on the part of the wife. The truth may be that he does need to change and is unwilling to do so. The wife, however, is immobilized by the futility of her efforts to change him and her discouragement about finding any approach that works.

One of the worker's greatest services can be to teach her that she cannot control her husband's drinking and that the need to stop must come from him. It is significant that members of the Al-Anon Family Groups have taken over the twelve steps of Alcoholics Anonymous. These women emphasize that they too are "powerless over alcohol"—that is, powerless against the husband's drinking. Along with teaching the wife to recognize alcoholism as an illness, the caseworker also needs to convince her that "no wife ever made her husband an alcoholic, therefore no wife can 'unmake' her husband or be held responsible for his recovery." [13]

If the wife is reassured by this knowledge, she can usually recognize that her direct attack on the drinking has been futile, and perhaps she can begin to abandon it. Her relationship with the caseworker can be the vehicle by which she adopts a new attitude of "letting go" and holding her husband responsible for his drinking. If the caseworker believes it appropriate, he advises her directly not to hide or destroy the liquor. A harder lesson for her to learn is that her husband's motivation to recover is likely to increase if she stops protecting him from the consequences of his drinking. Despite the real stress of living with an alcoholic, the wife is not an innocent victim but an active participant whose interaction with her husband produces an increasingly and mutually destructive situation. Alcoholics are past masters at arousing in persons close to them not only hostility but also anxiety and protectiveness. The protectiveness may arise in part from the traditionally condemning attitudes of members of our society toward uncontrolled drinkers. Thus the typical wife of an alcoholic makes excuses to her husband's employers, relatives, and friends; she puts him to bed, covers his bad checks, signs him out at the hospital, and bails him out of jail. The alcoholic's illusion of omnipotence is reinforced by this kind of protection, and he is able to continue denying his problem and his need for help. The alcoholic needs to change, but if the wife is to help him become motivated for treatment, she too must change: she must allow him to drink and let him experience the consequences of his drinking.

This new approach may temporarily make the situation more difficult, and during this period the wife may need much support in putting her new insights into effect. Professional workers, however, have repeatedly observed that when the wife changes her attitude and stops nagging and treatening her husband, when she stops protecting him and making direct efforts to stop his drinking, he may express a desire for help and move toward getting it.[14] Thus the wife, through changing her behavior as a result of her new understanding, enables her husband to change. Even if he does not stop drinking, the wife may react less to it; she may be less anxious and vacillating and better able to utilize her strengths in her own and her children's behalf.

Workers frequently note the wife's defensiveness about examining her role in the marriage. Denial, displacement, and projection are characteristic defenses often described in the literature. The realities of active alcoholism are so painful and so obvious that it is easy to understand the wife's tendency to displace all her difficulties onto her husband's drinking. On the other hand, a wife may have a deep fear that she is to blame, particularly if his drinking began after the marriage. She feels she has failed him. Jackson believes that in nonthreatening situations she readily admits her fears about her responsibility for his drinking and the family disturbance.[15]

Several social workers who report success in treating wives of alcoholics suggest avoiding any direct exploration of the role the wife may have played. Cathrin Peltenburg says that the wife "should not be suddenly confronted with her role in the situation." [16] Askey suggests that the worker should listen carefully for the wife's expression of her contribution to the problem, but should initially avoid trying to establish a casework relationship on the basis of her self-examination.[17] The worker should proceed slowly and supportively until the wife feels secure in the relationship. Initially, she may be threatened by any exploration in such areas as her sexual adjustment and her relationship with her parents. History-taking in any formal sense may need to be postponed.

The Wife who Remains in Treatment

The early phase of casework with the wife has been stressed in this paper because the establishment of a helping relationship seems to pose the greatest challenge to the caseworker. If the wife remains in treatment, the importance of the specifics of alcoholism will diminish while the generic aspects of marital and family counseling will come to the fore. By this time, one of several alternatives appears possible. In a few cases, the wife will decide to separate from her husband, and the worker can help her and the children leave this destructive situation and re-establish themselves. In some cases the husband will continue his drinking, but the wife can be helped to accept this behavior with less anxiety and hostility and to function better both as a person and as a mother. The most favorable possibility, of course, is for the husband to seek treatment from either a professional source or A.A. If he is receiving help and if the wife, after accepting referral to Al-Anon, breaks off her contact with the family service agency, the worker need not be apologetic about his limited accomplishment. Many spouses are able to improve their social functioning through the efforts of A.A. and Al-Anon.

If the wife remains in treatment, however, she

can be helped in many areas. Should her husband relapse, she needs reassurance that their efforts have not failed entirely and she needs help in gaining the courage to try again. She may find, to her bewilderment, that in some ways a sober husband is more "difficult" than an active drinking one. After joining A.A., he may become so engrossed in its activities that he neglects his family. To meet this problem the wife can accompany him to open meetings or participate in Al-Anon. The worker may need to help her accept the fact that her husband's absorption in A.A. is necessary for his recovery and that eventually he will achieve a balance. The wife may have difficulty in relinquishing the responsibility and authority she perforce had to assume while her husband was an active alcoholic. If she supported the family either partially or entirely, if she had to make all the decisions, if she functioned as both mother and father, she may learn that she enjoyed possessing so much authority and dislikes returning any of it to her husband. In the light of his good intentions and broken promises in the past, she may be doubtful of him and afraid to trust him. If she is not basically disturbed, the worker can help her increase her self-understanding and her warmth and respect for him. Many a wife finally comes to realize, after her husband achieves sobriety, that drinking is not, after all, the only problem or the only cause of their marital conflict. At this point in treatment, the basic principles of marriage counseling become more pertinent than the specifics of alcoholism.

Summary

People seeking help for personal difficulties select, perhaps in some not fully conscious way, the resource that seems to match their formulation of the problem. As a result of nearly twenty years of public education programs about alcoholism, individuals and families specifically seeking help in dealing with this illness are now likely to apply at specialized alcoholism resources. The family service agency, on the other hand, seems to be a resource chiefly for the wife whose alcoholic husband is not motivated to seek treatment at the time of her application. Her complaints about his drinking indicate that she has little awareness of alcoholism as an illness. Frequently, the entire family presents a wide range of psychosocial problems. These families comprise some of the most difficult and challenging cases.

In this paper the deliberate intent has been to overemphasize the importance of social stress factors and the specifics of alcoholism and to de-emphasize the importance of the underlying personality disturbance. Actually, of course, the alcoholic family graphically exemplifies the interplay of person and situation. There is far less likelihood, however, that the caseworker will ignore personality disturbance than that he will pass over the stresses inherent in living with an active alcoholic. The wife's attention, on the other hand, is focused on the stress situation, and unless she and the caseworker can find some meeting ground in the first interviews, she will lose at least temporarily the feeling that help is available. Accepting her complaints, helping her deal with reality problems, imparting factual information about alcoholism, and giving her support so that she can relinquish her protectiveness and her futile measures to control her husband's drinking have proved to be effective techniques in working with the wife of an alcoholic. Self-examination, work on personality disturbances that underlie the problem, and insight come slowly. In the meantime, the husband may respond to changes in his wife's attitudes by increasing his motivation to seek treatment. At the very least, the caseworker has gained an opportunity to help the wife function more comfortably and more adequately; at most, recovery for the entire family becomes possible.

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ALCOHOLICS ANONYMOUS

as resources

ALCOHOLIC

Published by permission of the author, this article was originally presented as a paper at a workshop sponsored by the Chicago Committee on Alcoholism, the Illinois Division of Alcoholism, and the National Institute of Mental Health in Aurora, Illinois, March 1-3, 1962. Margaret B. Bailey, D.S.W. is director of research for The National Council on Alcoholism, Inc.

Social workers and other professional people appear to share somewhat mixed feelings toward Alcoholics Anonymous and the Al-Anon Family Groups as community resources to which clients may be referred. Virtually all social workers have at least minimum acquaintance with A.A., although some are not familiar with Al-Anon, a fellowship for relatives of alcoholics which is similar in conception and general functioning to the older and better known A.A. fellowship. I have occasionally heard professional people express attitudes which attributed almost magical powers to A.A. and which perhaps reflected a sense of relief that responsibility for a difficult alcoholic could be transferred to the members of the A.A. fellowship, once a referral had been effected. On the other hand, there are those who question the wisdom of referring alcoholics and their families to such entirely non-professional groups. The prevailing attitude of social workers seems to be positive, but there is little depth of understanding of the therapeutic mechanisms involved in the two fellowships.

and AL-ANON for the and HIS FAMILY

BY MARGARET B. BAILEY, D.S.W.

General Characteristics of the Fellowships of Alcoholics Anonymous and Al-Anon

From its original two members, who came together in 1935, A.A. has grown to a worldwide total of 8,615 groups with about 300,000 members. In the United States in 1961, there were 5,875 groups with an estimated membership of 216,000. In addition, upwards of 700 groups meet in prisons and hospitals. Al-Anon, founded by the relatives of recovering alcoholics in the pioneer days of A.A., now numbers approximately 1,460 groups in the U. S., with an estimated membership of 22,000 (1). These groups have the advantage of ready availability in nearly all communities except very small ones. There are no dues or fees (though voluntary contributions are collected at meetings), and for A.A., "the only requirement for membership is a desire to stop drinking." In practice, this means that any one is a member who states that he or she is a member. Any spouse, relative or friend of a problem drinker is similarly eligible for membership in Al-Anon, whether or not the drinker belongs to A.A. This absence of formal requirements and of any dues structure means that membership statistics are never very exact, but this very openness carries with it enormous therapeutic significance for individuals and families who suffer from an illness which has been greatly stigmatized by our society.

These two fellowships, founded by alcoholics themselves and by their wives, have met a need

which, in the early days, was not at all filled by professionals. In fact, professionals, along with the rest of society, generally considered alcoholism to be hopeless, though a very few afflicted individuals had recovered on their own or perhaps through the help of an understanding physician or through the approach of religious experience. Alcoholics Anonymous, however, provided the first demonstration that mass recovery from alcoholism is possible. If no one else could or would help them, alcoholics would (and did) learn to help themselves through a fellowship of mutual support. Though statistics on the extent of A.A. successes and failures are not available, it is generally agreed that this fellowship has led to a greater number of recoveries than any other method of treatment. A.A. has been paid the compliment of imitation, and there are now similar self-help fellowships for mentally disturbed individuals, for narcotics addicts, gamblers, and obese people. The current interest in professional group therapy for alcoholics, which many people believe to be superior to individual therapy for these patients, appears to have caught hold in large measure because of the marked success of A.A.'s methods.

I do not plan in this paper to trace the history of A.A. and Al-Anon or to describe their overall structure in any detail. Both fellowships have extensive literature, including several published volumes, which are worth reading by any professional person interested in developing a working relationship with A.A. and Al-Anon (2,3,4). In addition, there are at least two useful papers of a general nature by Lee and by Trice in recent professional journals (5,6). Instead, I shall try to focus on a discussion of points which will be most helpful to social workers in decisions about referring clients and in subsequent cooperative working relations with the two fellowships.

A few words about structure are needed, however, in order to set the rest of the discussion in context. The word "fellowship" rather than "agency" or even "organization" has been used deliberately because of the minimum of formal structure which characterizes A.A. and Al-Anon. Both do have national headquarters offices, but these are service centers without authority over the individual local groups, which possess complete autonomy. In larger cities, there is usually an intergroup office which facilitates communication among the groups and acts as an information center for members and the public. But again, this intergroup office has no authority over the affairs of the individual group. To the outsider, it often seems surprising that the several thousand loosely-knit groups remain united as a fellowship. The answer seems to lie in the A.A. program (the twelve steps), in the conviction and influence of a few older members in each group, and in the growth of shared customs which have been formalized in the twelve traditions, providing a guide to general policy and functioning. Al-Anon uses the same steps and traditions, with minor modifications adapted to the families of alcoholics.

Although there is a common core of A.A. and Al-Anon tradition and practice, the local autonomy of groups results in considerable variation. This is one of the reasons it is difficult to generalize about the fellowships, since individual groups will differ in membership composition and in general atmosphere. In one city, for example, I visited A.A. groups which were far less permissive in tone than those I had been accustomed to in New York. Though there is no policy of exclusion, a process of self-selection tends to result in groups which are fairly homogeneous in race and socioeconomic status. This is particularly true in a large community, where there may be several dozen, or even several hundred, groups.

Most A.A. groups have "open" and "closed" meetings, and some have special sessions for newcomers. An open meeting may be attended by any one, including not only members, but interested professional observers, friends and relatives of members, and drinkers who are exploring the possibility of affiliation but who may not yet be able to acknowledge their alcoholism. No personal commitment of any kind is involved in attending an open meeting, and many drinkers who are still unready to call themselves alcoholics have been willing to visit such a meeting to see whether "A.A. is for them." Sometimes they decide it is, and sometimes they do not, but in the latter case, they often return after a period of time. In A.A. parlance, "a seed has been planted." At open meetings, several A.A. members usually tell their personal "stories," including an account of their drinking, how they reached A.A., and how life has

developed as a result. Closed meetings, on the other hand, are discussion groups for alcoholics only. In these sessions, personal problems are recounted, and group suggestions and support are offered.

For the social worker, attendance at the open meetings of several A.A. and Al-Anon groups is a rewarding experience and is highly desirable as a prelude to making effective referrals. In addition, the caseworker may wish to visit the intergroup office, if there is one, or to establish a relationship with one or more A.A. and Al-Anon members. Then when an occasion for referral is at hand, channels of communication will already be open and the client will be more likely to reach a congenial group. Referrals are usually more successful when there has been an informal matching of the prospective member with the group.

The Contribution of A.A. to the Alcoholic's Recovery

The newcomer attending his first A.A. meeting usually senses immediately the uncritical, accepting atmosphere, which is utterly different from the condemnation and rejection he has been experiencing with family, employers, or friends. In Lee's words, "No one asks him where has he been; no one asks if he is sorry; no one suggests that he ought to be ashamed of himself" (5). A.A. members have frequently described their own initial reaction as a feeling that they have joined the human race again. Some observers, such as Button, have questioned whether A.A. is really so accepting (7). In my own experience it would appear that groups differ considerably in the degree of active hospitality which they offer. Some have hospitality committee members posted at the door, while others take a less outgoing approach. Trice, too, has observed that some groups tend to overlook the newcomer (6). For this reason, it is important at the time of referral to arrange for sponsorship, rather than merely to give the client information as to where a meeting is available. A.A. has a system of sponsorship, whereby a more experienced member becomes a guide and mentor to the newcomer, accompanies him to meetings, sees that he meets other members, answers his questions, and generally maintains contact with him.

The first conscious reaction of the newcomer is often one of hope. Entering the meeting full of apprehension and doubt, he will usually find a roomful of people who look healthy and well cared for, who are moving about and talking together with frequent laughter. Often the newcomer will express disbelief that these are "really alcoholics." Having been convinced that they are, from the personal stories told during the meeting and the informal conversations which precede and follow the program, the newcomer will consciously experience the feeling: "If they can do it, I can." This new belief is completely at variance with the hopelessness which the active alcoholic ultimately reaches as a result of vain efforts to stop drinking by himself, hopelessness which has often been reinforced by significant others in his environment.

In the early weeks of his A.A. contact, the beginner learns a good deal about alcoholism, a new set of attitudes, and several practical tools for everyday use. The concept of alcoholism as an illness often brings a sense of great release and a feeling of respectability. Whether the newcomer regards this illness as physical or mental, or both, probably does not matter very much; many find reassurance in stressing the physical aspects, especially at this stage, and it is of course true that some are in very urgent need of medical care. The newcomer will learn about the compulsive nature of his drinking and the idea that it is the first drink which gets him into trouble. This may come as a surprise, since he may have believed it was the third or the fifth drink, or the tenth, which caused the difficulty. Avoidance of the first drink then becomes the immediate goal, but with great wisdom A.A. suggests no lifelong promise to abstain. Instead it is pointed out that the new member may try to stay sober for just twenty-four hours at a time and then for another twenty-four. Abstinence on a one-day basis breaks time into manageable units at a period when the new member's struggle not to drink may be very intense.

He is also introduced to a whole series of new activities and new human relationships, which are set in opposition to all his drinking associations. Not only is he encouraged to attend frequent meetings, but he may exchange telephone numbers with several members in addition to his sponsor. These people will call him often, and he is free to call them whenever he wishes or needs help. Thus A.A. provides a true therapeutic community and a degree of support which no professional person or agency could possibly offer

on an outpatient basis. As the newcomer begins to use this help, he develops a sense of belonging and participates in a network of shared problems and mutual aid. In the words of the A.A. preamble, which is customarily read at the beginning of each meeting, the members "share their experience, strength and hope with each other." The sponsor and other older and more stable members provide models, and continued attendance offers repeated opportunities for contrasts with the drinking self and for rededication to recovery (8). Some authors, like Button, have been critical of the constant reiteration of the advantages of sobriety (7), but it seems clear that many alcoholics need this kind of reinforcement. To the outsider, the repeated emphasis on non-drinking may seem as compulsive as the drinking ever was; perhaps it is, but the still sick alcoholic needs to become as totally absorbed in sobriety as he formerly was in his actively alcoholic way of living. Members who remain in need of this constant reinforcement will continue to spend most of their non-working hours in A.A. activities. Others, though still participating, will gradually begin to move out into the life of the community. Most A.A. members will, however, feel some degree of enduring need to reteach themselves through helping other alcoholics toward recovery. This assistance to newcomers is also an expression of gratitude and of fellowship. Stewart, applying Freudian concepts to this process, has suggested a growth process beginning with object choice or attachment to the sponsor, going on to identification with the sponsor, and eventuating in object love expressed through help to newcomers (9).

These interpersonal relationships available through the group are generally regarded as one of the major therapeutic benefits which A.A. offers to its members. In addition, genuine recovery requires changes in the alcoholic's self-concept and in his spiritual orientation. His inner acceptance of his alcoholism may occur almost immediately after his entry into the group, or it may require a considerable length of time. A.A. members draw a distinction between "admitting" their alcoholism, which is regarded as an intellectual recognition, and "acceptance," which involves the alcoholic's deepest feelings about himself. Similarly, Tiebout, a psychiatrist, distinguishes between "compliance," which could lead to abstinence of a grudging and usually temporary nature, and "surrender," which is necessary for true recovery. This surrender he regards as a conversion phenomenon, involving "a deep shift in emotional tone, not consciously willed, but arising from changes in the unconscious psychodynamics" (10). The prerequisite for such an experience, Tiebout believes, is a state of hopelessness and an inner conviction that one cannot continue in the same direction one has been going. Hence the first step in A.A.'s program: accepting one's powerlessness over alcohol.

There is no attempt at this stage to gain insight into the reasons for one's drinking; in fact, the newcomer is generally discouraged from undertaking any such introspection. Older members know that searching for the causes may be pure intellectualization and may actually impede acceptance on a deep emotional level. This, I believe, is one of the reasons for professional ambivalence about A.A. Professional people have generally been trained to regard alcoholism as a symptom of profound underlying disturbance which must be resolved, so that the individual will no longer have a need for compulsive drinking. This approach has not been notably successful, but many professionals are still reluctant to shift to the point of view that the "symptom" is so gross that it must be overcome before its roots can be explored. A.A., on the other hand, says in effect that it does not matter at the outset why the person drinks. It only matters that he accept his powerlessness over alcohol. After he has attained sobriety, he can, if he is willing, work on a lifetime program for recovery, taking inventory of his strengths and weaknesses, correcting his shortcomings, and making amends to others. Though the terminology is different, these steps in the A.A. program seem to me to exhibit, though on a conscious level, a considerable parallelism with the process of psychotherapy.

The spiritual emphasis of the program and the concept of surrender to a higher power have undoubtedly deterred some alcoholics from trying A.A. and discouraged some newcomers from continuing. The second of the twelve steps in the A.A. program states that the members "came to believe that a Power greater than ourselves could restore us to sanity." The third reads: "Made a decision to turn our will and our lives over to the care of God as we understood him." Active alcoholics generally suffer a profound alienation, not only from themselves and their

fellow human beings, but also from a sense of place and purpose in the universal scheme of things. Some are agnostics or atheists. Hence the second and third steps may appear as tremendous obstacles. A.A. is not, of course, a religious group in any denominational sense, and each member is free to use or develop his own conception of spiritual power. Older members will often suggest that newcomers who are having difficulty with these steps may take the group, or A.A. as a whole, for their "higher power." Recovery is certainly possible with this kind of humanistic ideal, though the "higher power" for most members tends to become something more than this.

Readiness to Affiliate with A.A.

In this brief sketch, I have outlined some of the benefits of A.A. for those who affiliate. On the other hand, an unknown, but apparently large, number of alcoholics are exposed to the fellowship, but do not join it. In an attempt to understand this phenomenon, Trice compared a group of A.A. members with a sample of nonpsychotic hospitalized alcoholics, who had been exposed to A.A. but had not affiliated. He found a number of significant differences between the two groups (11).

Before they ever attended a meeting, affiliates seemed to regard themselves as people who could share their feelings and problems with others. They had already lost their drinking friends and expressed the feeling that drinking brought more trouble than pleasure. They tended to regard the symptoms of alcoholism (blackouts, loss of control) as pathological, in contrast to the non-affiliates, who saw these manifestations as "necessary by-products of a recreational outlet, not an illness to be treated" (11). These non-affiliates had not as a rule lost their drinking friends, and they tended to receive support in their drinking from one or more family members. They were also more likely to have will power models— i.e., they cited the experience of a grandfather or uncle, who had one day just decided to stop drinking and never touched another drop.

At the time of first attendance, affiliates had some clarity of expectation as to what the meetings would be like and had been exposed to favorable definitions of the sincerity of the members. Non-affiliates, on the other hand, had heard that members attended meetings and drank on the side. They also expressed greater class sensitivity and more feelings that "only big shots belonged." Affiliates were more likely to be sponsored, and through their sponsors to meet other members, which led to participation in informal activities before and after the meetings. The wives or girl friends tended to accompany those who affiliated to the meetings and to support what they saw and heard. In contrast, the wife or girl friend of the non-affiliate often forced the alcoholic to choose between A.A. and herself (11).

I have cited the findings of this very helpful study in considerable detail because they point to a significant role for the referral source in the preparation of prospective members. Some of the differences between affiliates and non-affiliates are deeply embedded in the life situation of the person, and some (for example, the welcome to newcomers) are the responsibility of the A.A. group itself. The referral source, however, can make sure that the prospective affiliate attends his first meeting with some clarity of expectation and with a favorable definition of the membership. If channels of communication have already been established, sponsorship can more readily be arranged and the new member can be informally matched to a group that is likely to be congenial. Finally, if the referral source has a relationship with the wife, as is apt to be the case in a family agency, she can be given interpretation and support which will enable her in turn to support her spouse in affiliation with A.A.

In a current study at the National Council on Alcoholism, we have found that level of education seems to be related to A.A. attendance and to its helpfulness, as judged by the wives of alcoholics whom we have interviewed. As shown in Table 1, the husbands who had terminated their education short of high school graduation were less likely than the better educated men ever to have attended A.A. Though we did not interview the alcoholic husbands, we did ask the wives for their judgments about the helpfulness of A.A. For those men who had been exposed to A.A., there was a significant increase in benefit, associated with higher education. The wives of three-quarters of the college men believed that A.A. had helped their husbands, in contrast to the wives of half of the men who had stopped short

TABLE 1

Husband's Education, Attendance at Alcoholics Anonymous, and Its Helpfulness as Judged by Wives

Educational Level of Husband	Total	Attended Alcoholics Anonymous		Wife Judged A.A. Helpful	
		Number	Percent	Number	Percent of those who attended
Less than high school graduation	131	71	54.2	36	50.7
High school graduation	45	35	77.8	21	60.0
Some college or more	81	61	75.3	45	73.8
Unknown	5	2	40.0	—	—
Total	262	169	64.5	102	60.4

TABLE 2

Husbands' Drinking Status and Spouses' Attendance at Alcoholics Anonymous and Al-Anon

Husbands' Present Drinking Status	Past or Present A.A. and Al-Anon Attendance[a]			
	Husband A.A. AND Wife Al-Anon N = 98	Husband A.A., Wife not Al-Anon N = 70	Wife Al-Anon, Husband not A.A. N = 14	Neither A.A. Nor Al-Anon N = 76
Still drinking	29.6%	45.7%	85.7%	72.4%
Sober less than six months	20.4	22.9	14.3	13.2
Sober six months or more	44.9	21.4	—	14.5
Unknown[b]	5.1	10.0	—	—

[a] In four cases, A.A. or Al-Anon attendance was unknown.

[b] In cases where the husband's drinking status was unknown, the spouses were separated, and the wife was not in touch with the husband.

of high school graduation.

The Al-Anon Fellowship

Many of the descriptive statements and comments offered up to this point will apply also to Al-Anon, the fellowship for wives, husbands, relatives and friends of alcoholics. Al-Anon follows a pattern similar to A.A. and uses the same twelve-step program of recovery and the same twelve traditions to govern its policy and practice. Al-Anon members, according to their own statement of purpose, "are banded together to solve their common problems of fear, insecurity, lack of understanding of the alcoholic, and of the warped family relationships associated with alcoholism" (4). Most of the members are wives, though at any meeting the observer will usually see a few fiances, mothers and sisters of male alcoholics, and often a few men, who are husbands of women alcoholics. The drinker may or may not be an A.A. member and may or may not have achieved sobriety.

Al-Anon was founded during the early years of A.A. by a group of wives of recovering alcoholics, who began to realize that difficult family problems often persisted even after the drinker had gained sobriety. These women thus began to meet, in a fashion similar to that of A.A., to discuss their own problems. Having included some Al-Anon members in our research with wives of alcoholics, I have had occasion to visit a good number of groups. The feature which has perhaps most impressed me is the absence of complaints about the alcoholic behavior of the husbands. Many newcomers first attend Al-Anon full of self-pity, sure that their experiences are unique. They are met with understanding and with the reassurance that other women, too, have known similar realities in living with an alcoholic spouse. Very quickly, however, the newcomer learns that the group atmosphere is one of self-scrutiny with a view to change in attitudes and behavior. I suspect that some women who are not motivated to change may drop out at this point but, on the other hand, it may be easier to accept an approach of self-examination from one's peers than from a professional counselor. Knowing that other wives have shared similar experiences reduces the need for defensiveness. Al-Anon offers the same group support to its members as does A.A. with the alcoholic.

The first lesson to be learned in Al-Anon is that the spouse, too, is "powerless over alcohol." As the fellowship's book, *Living with an Alcoholic*, points out, the wife may regard herself as either the victim or the cause of her husband's illness. She may have aggravated his drinking by pleading, cajoling, pampering, or scolding—methods which are never effective—but the causes of his alcoholism lie deeper, and he is the one who must make an effective decision to stop. The wife must wait for him to take this responsibility, but meanwhile, she can change her attitudes and help herself "lead a saner, happier and more effective life" (4). Paradoxically, it is often the wife's freeing of herself from involvement in the drinking and its consequences that helps the husband to take responsibility for himself.

The wife's acceptance of her powerlessness over his alcoholism brings profound release and enables her to direct her attention to her own problems. The self-righteousness and self-pity which often characterize the spouses of alcoholics are discussed in the meetings, and it is suggested that the husband may have suffered from the wife's martyr-like attitude and from her undermining of his authority in the family. Frequently at this point alcoholism is also reflected in sexual problems, and it is pointed out in the meeting that these may be a symptom of his illness, and that perhaps the wife has been rejecting him "unkindly and unjustifiably," even when he is sober. In general, then, the wife is helped in specific ways to accept her husband as a sick person.

Should he attain sobriety either through A.A. or some other method of treatment, she will also find support from her fellow Al-Anon members in the transitional period which follows. Many wives have resented the time which newly sober husbands have devoted to A.A., and some have experienced bitterness at their spouses' recovery through an agency other than themselves. Another problem lies in the area of the wife's gradual relinquishment of family responsibility to her husband as he recovers. With all of these readjustment difficulties, the support of Al-Anon can be most helpful. Should the husband not attain sobriety, the wife can still use the help of Al-Anon to function better and more comfortably as a person and as a mother. A final discovery, perhaps not achieved by all members, is the realization that "many of our defects have little relation to our partners' alcoholism" (4).

A word should be added about the Alateen groups, which are beginning to be established in some localities as a special variant of the family group idea. Older children have often attended Al-Anon meetings, but it remained for a teenaged boy in 1957 to initiate the idea of separate meetings for adolescent children of alcoholics.

The Alateen groups meet under the aegis of Al-Anon and attempt to help their adolescent members accept the parents' alcoholism as an illness. Special attention is devoted to problems of bringing friends or dates into the home, when the parent may be drinking. The teen-ager is helped to learn how to cope both with the alcoholic parent and with the reactions of the neighborhood and community. These groups are still so new that evaluation of their contribution to the adjustment of alcoholic families seems premature at this time.

The Role of A.A. and Al-Anon in Recovery

In this brief presentation, I have tried to communicate some thoughts as to the ways in which A.A. and Al-Anon work, the benefits derived from membership, and the kind of alcoholics most likely to affiliate. There has been little or no research on the results of A.A. and Al-Anon participation as compared with the effects of other forms of treatment. Hence before concluding, I should like to present one piece of evidence which bears on the success of the two fellowships. In the National Council on Alcoholism's current study of wives of alcoholics, we have interviewed a total of 262 such women, drawn from the caseloads of various community resources. One hundred sixty-eight of the husbands had had some experience with A.A., and 112 of the wives had attended Al-Anon. This does not mean that all these people were regular members, but simply that they had had some contact, past or present. Sixty-three of the women were current Al-Anon members, recruited for the research at their weekly meetings, and 49 were drawn from the caseloads of other agencies (an alcoholism clinic, two courts, and an alcoholism information center) but happened also to have had contact with Al-Anon. Table 2 demonstrates a clear relationship between A.A. and Al-Anon membership and the husband's abstinence. Sobriety, it is recognized, is not tantamount to recovery, but it is the necessary first step. Among our families, the husband was far more likely to have achieved six months or more of sobriety if he had attended A.A. *and* his wife had had Al-Anon experience. Where both spouses had had such contact, the results in terms of continuing sobriety were better than in cases where only the husband had attended A.A., or only the wife had attended Al-Anon, or neither had had contact with these fellowships. The men were most likely to be still drinking if neither spouse had had such contact, or if only the wife had attended Al-Anon, al-somewhat better if only the husband attended though it should be noted that there were only 14 cases in the latter category. The results were A.A. and the wife did not seek Al-Anon help, but they were most favorable when both spouses had contact with these fellowships.

These findings suggest that A.A. and Al-Anon are extremely valuable resources for the referral of alcoholic clients and their families. This does not necessarily mean, of course, that the social worker, or any other professional person, must decide whether to refer or to keep his clients. Professional help and affiliation with A.A. and/or Al-Anon should and can complement, not rival, one another. In recent years, it has begun to be apparent that increasing numbers of alcoholics and their families are seeking help through a combination of professional treatment and membership in A.A. or Al-Anon. Such collaborative efforts need to be greatly extended, but it is encouraging to be witnessing at least the beginnings of joint efforts, professional and non-professional, to work together in the interests of the alcoholic's sobriety and of long-term recovery for both him and his family. In the past, the attitudes of social workers toward the alcoholic have been shaped by a rejecting society, of which they were an integral part. In view of the achievements of A.A. and Al-Anon and other therapies which are developing, there is now every reason for the enlightened social worker to feel hopeful about the alcoholic's potential for recovery.

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NOTES

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Some Considerations Concerning Patients Who Come to the

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Most social workers and psychiatrists appear to agree that there are some basic fundamentals essential to the Intake Interview (or Initial Interview) in any clinical or social agency setting. I would like to review these briefly before turning to what seems to me to be crucial to intake in an alcoholic clinic. First, and one of the most difficult to master and stay mastered, is the precept that the interviewer or therapist is always a living participant in a full-life drama and not a fact-finder in a sterile clinical laboratory. This means that the interview is an emotional experience for both and the intake worker must watch the responses of both! Then, too, as all writers in the field indicate, there is that need for an accepting climate—that is, a comfortable and relaxed atmosphere, and for warmth and acceptance on the part of the worker. "The emphasis should be upon putting the client at ease, encouraging him to talk, and interpreting his behavior rather than on obtaining material for a case-record." Fact-gathering, as such, is theoretically out, even though we are all often reduced to it when we are anxious or stumped as to where to go next with the patient. This has been described as a "security operation" in which the worker falls back into the old medical tradition of inquiry and firming medical facts.

What are the general goals or aims of all Intake Interviews? First, we all want to establish a relationship with the client by establishing a warm human contact and a feeling of mutual appreciation. Secondly, we want to obtain a groundwork of informative insights on which we can make a rough appraisal of our new client's capacities to utilize our services and for establishing a pattern of how he uses himself and others in solving problems. Thirdly, and of such importance with our 'ego-battered' alcoholic, we want to reinforce our applicant's motivation so that he will return. Sullivan's statement of this is a masterpiece: "The quid pro quo which keeps people moving in this necessarily disturbing business . . . is that one is learning something that promises to be useful. Insofar as the patient's participation . . . inspires . . . a conviction that the psychiatrist (and here may I interject, or social worker) is learning not only *how* the patient has trouble, but *who* the patient is and with whom he has trouble, the implicit expectation of benefit is in process of realization."

These factors I have mentioned are all based on the consideration that the patient usually comes into a clinic or hospital seeking help of some sort. This means that he is desperate, and, at least at the moment of making the appointment, he or she is genuinely involved in at least some slight inner-inspired impetus toward change.

In our outpatient clinic for treating alcoholics, patients more often than not come in, not because of any inner desperation at all, but because an irate mother, or desperate wife or an authoritative social agency has decreed that our client must seek help with his alcoholism, or else . . . The 'or else' may vary, but, in essence, it is the same for all—they walk in with a gun in their back and as soon as the gun is removed, most of them will fly away. How can we approach this miserable person, itching under the painful chains that temporarily bind him to us? This is the delicate problem I will attempt to throw some light on today.

We all know that the Intake Process, with its

he Intake Interview With Alcoholic Clinic Under Duress

full history picture and its mutually satisfactory testing of worker and patient, will usually take more than one interview. Nevertheless, we must help this person who comes to us under duress to become genuinely involved in the first interview, or we have nobody to work with in succeeding interviews! Lest anyone be disappointed with what follows, let me make it clear that no one has a foolproof formula for holding alcoholics and that what I have to offer in this paper is nothing but considerations or guideposts for further testing and experiment on the part of all of us.

I do not think that lack of desperation is the basic criterion of duress. Critical is whether or not the desperation is an essential factor to the patients' own orientation at the moment, or is their emotional organization (no matter how unsound) well-knit around defenses provided by alcohol, with the desperation, and thus the duress, felt only by an outside authority? Often our patient, brought in by disgusted policemen, guilty and anxious sister, or martyred and near-desperate wife, has worked out an emotional organization which is deeply satisfying to him, even though it is a self-destructive pattern. We cannot here go into all the elements of the alcoholic personality—we will leave for the psychiatrist the orality, the immature regressive elements, the homosexual strivings, and other configurations not pertinent to our considerations today. . . .

When our alcoholic comes to us by undue force, it is significant that he has worked out a formula for resolving his anxieties and expressing his hostilities which puts these factors outside himself. His hostilities are expressed via passive-aggressive through the drinking. When he is sober, all responsibility can be denied. Hence, our patient himself is not involved in this first interview in our clinic—it is his wife, his mother or the police that have the feelings, from which he himself may be completely divorced. I have observed that he will answer your questions more or less fully or openly depending on many other factors—is he in hangover or withdrawal, has his wife just threatened to leave, have the police just given him the choice between prison and your treatment facility? In every instance, however, the alcoholic will express little but positive or even affectionate feelings for his family. He will tell you that they have been long-suffering, he has caused them a great deal of anguish, he does not know what he would do without them. As the situation is, warmth, acceptance and understanding on the part of the worker, even if offered most generously, even bountiously, are not

enough to establish a giving relationship between client and clinic. In my limited experience, the alcoholic will not express his hostility at force (physical or psychological) used in bringing him into the clinic or at the person who used the force. The main exception to this appears to be when the police are the authoritative agents responsible for bringing him to us. To my thinking, this hostility, real and yet denied, is a powerful factor working against relationship with the clinic unless it can be recognized and owned by the patient. At this point, it can be a force freeing the patient to move toward treatment rather than a drag keeping the self from involvement in the Intake Interview and beyond. Here, it seems to me, it should be possible for the skilled worker to cut through the denial, without overwhelming the patient and driving him away from your agency by forcing upon him an excess of insight into his hostile pattern of denial and rebellion. As has been said by others, "A bold attack which shows that the therapist or social worker knows what he is about, that he can lay his finger on the trouble and is not afraid, may not only be very reassuring but may go far toward helping the patient overcome the ever-present tendencies to evasion, whether these are conscious or not." This may mean more dynamite than we can handle, or, in fact, that the alcoholic can bear to handle in one interview, when he has little transference strength to reply on. Too much hostility can be overwhelming and we do not want to encourage the patient to end his first interview with us at the nearest bar—this is bad for the patient's morale, hard for the family to accept, and pretty tough for us, too!

As I mentioned earlier, the alcoholic will rarely or never dwell on his anger and resentment at being forced into the clinic. Before I had formulated for myself the necessity of helping the patient to express this, I had many patients who did not use such a general question as "How do you feel about coming here?" to express anything but positive, at least verbally. Mr. Stevenson, for example, is a 46 year-old mechanic who can build and design machinery. He came in, under duress, after his wife had made the first appointment. He arrived two hours late, and somewhat drunk, so his speech was slurred and his movements were slow. Mr. S. has been drinking since 1934. Interwoven with his drinking history and his

atient verbalize his feelings about being forced into the clinic.

work history, Mr. S. referred to his wife many times and told how she hollered at him and condemned him for drinking, often in front of the three children. Mr. S. veered away, however, when I directly questioned his feelings about his wife. His retreat into verbal confusion was difficult to follow with clarity. In another part of this same interview, he spoke indirectly of his way of handling problems and of how he learned that way, when he told of a quarrel between his parents in which he attempted to interfere. He was severely reprimanded, and, as a direct consequence, he ran away to sea immediately afterwards. Mr. S. thus indirectly expresses a tremendous amount of hostility toward his wife. Also, he tells us how he handles painful problems in the way and manner he arrived in the clinic. Beyond this, he challenged us to behave as an authoritative, hostile and demanding figure as his mother and his wife appeared to him to be. Nevertheless, our acceptance of him without reprimand or hostility was not sufficient to establish rapport. His indirect expression of hostility was, I now think, inappropriately accepted as sufficient exploration of feeling. He was not helped to verbalize directly his feelings about being pushed into our clinic. Whether for this reason alone, or for a complex of other factors as well, Mr. S. did not return. . . .

Another worker has noted that we should be careful to raise questions that "are clarifying but do not attack defensive reactions lest further defenses be mobilized, such as the client's withdrawal through fear, increase in anxiety or immobilization." Indeed, we cannot afford to blast away any patient's total defenses on the first interview (or any succeeding interview). Yet, we must obtain a foothold, as it were, beyond the massive defense of hostility and rebellion toward authority figures. It seems to me possible to extend our permissiveness to the point where we can accept a patient's inability to express hostility about his arrival here, at the same time that we clearly recognize with the patient that hostility exists, even though we may not yet be ready to talk comfortably about it.

A controlling sister and distraught mother accompanied Mr. Young to the clinic for his first appointment. The way to the clinic had already first been explored by another sister through an impromptu visit and several telephone calls. Mr. Young is 35 years old, has a 6th grade education and is a pants presser by occupation. He has lived all his life with his mother and sisters. As soon as he was settled in my office, I recognized with Mr. Young that I was familiar with why his sister felt that he needed help, but now I was interested in what seemed to him to be the difficulty. Mr. Young responded by describing his nerves, his drinking with a neighborhood bunch of friends, and his long and tedious job, all of which he thinks may be related. Then Mr. Young lapsed into silence. I commented that knowing how he had come in, I wondered if he had the feeling of being forced into the clinic. Mr. Young agreed and fell silent. How did he feel about that? "All right," was the response. I thought he might have some strong feelings about this. Mr. Young quietly remarked that there was nothing he could do. I thought there was something he could do—right here—he could express his feelings about this situation. Mr. Young responded that he would be honest . . . he feels that his family wants to help him and he is glad they have brought him in. We went on from here to talk of Mr. Young's early life on the farm, his subsequent work history and his present constant need to settle his nerves with alcohol. Thereafter, I again mentioned my concern about his family bringing him to the clinic. Again Mr. Young denied any angry feelings. Here, it seemed to me that this patient has been afforded ample opportunity to ventilate feeling around the process of arriving in the clinic. My focus had been exclusively on feelings about this rather than on feelings toward the family and the larger life context, either on his developmental history or his present day-to-day living situation. In this case, with a patient from an impoverished educational and social background, I took the responsibility for some of the verbalizations upon myself, when I told him that I knew it was probable that he could have angry feelings as well as "all right" feelings about being forced to come here—we could understand this and we could also understand how difficult it is to talk about such things. When he left, both the psychiatrist and I felt the prognosis was poor for continuing. Since, Mr. Young has continued with our clinic and has returned to work with the plan to tell the boss that he could no longer work such unreasonable hours. A month later, he is sober and "feeling well." It seems a possible con-

jecture to me that in this situation some of the family desperation, a correlate of Mr. Y's drinking, was accepted by Mr. Y. when his anger was comfortably recognized and accepted without undue emphasis.

It seems probable to me that this method of recognizing the patient's feelings and verbalizing them for him may be effective when a long history of passivity and denial make it inappropriate to force full verbal recognition from him. We do not want to be dentists, pulling painful teeth amidst the patient's screams of woe—the important thing is that our alcoholic knows from the caseworker that his true feelings about coming to our clinic under duress have been appraised and that he has been accepted with our full recognition that he does have a great deal of initial resentment about being with us. This serves to indicate something of our understanding of the problems that are far beyond his present ability to cope with and our current acceptance of him as he is now, full of hostility, dependence and ambivalence. If we force a statement to this effect from him, it might be so overwhelming that he would be too frightened and fearful of his own powerful feelings to expose himself to the danger of their being considered again before he has the ego strength (or strength of self) gained through the relationship to bear such heavy pressure.

The Worker Must Accept His Authority Role

As a concomitant of helping the patient recognize his antagonism toward the authority figure which pushed him into the clinic, it seems most desirable that both worker and patient be comfortable with the reality that the worker is an authority figure—a figure that the patient unconsciously tries to place in a punishing and parental role. The worker must accept for himself his own authority role. No matter how he longs to identify with the forlorn and miserable patient, he, at the moment, is authority—as proved by his appointment book, his office, and fundamentally his role as agency representative to the alcoholic. No amount of handshaking, relaxed setting of the office, or kindly well-intentioned words will obscure this. The worker who denies this to himself cuts off an immensely valuable avenue to establishing real rapport with the alcoholic. The worker who accepts this can more freely and comfortably encourage the alcoholic to test our hostile feelings against him, even perhaps by just a word or so in the Intake Interview.

This reminds me of one of my favorite patients —by which I mean, of course, a patient who appears to be doing well even with high odds against it. Joseph Donovan is a 32 year-old, white, near-illiterate bricklayer, who comes to us with a long history of maternal pampering, paternal sternness and escape from the stress of this emotional reality through alcoholism. Mr. D. came to us for screening after having been discharged from our Rehabilitation Center and returning to drinking and stealing from his parents within ten days. He was brought in by the police. I had never seen him before. His manner was ingratiating and subservient—his slenderness and immaturity of face made him appear ten years younger than his chronological age. After introductions, he told me of his relapse in such a fashion that it seemed that all were responsible instead of he—the community, for not having the right job open for him when he was ready for it, his father, for telling him off; his mother, for nagging and complaining. He can't understand why she would nag so much, as for example, over a simple little thing like his painting the family fence a sickly green instead of the white as she had asked him to paint. He voiced resentment at the court for what felt to him like dictating about the girl he wants to marry. I felt free to express empathy with some of his annoyance which I felt was probably quite real, and which it would have been unnatural of me not to express. From here, I went on to ask about his feelings about our Rehabilitation Center (to which he had been involuntarily committed). As we talked together, I expressed acceptance of the negative experience and then I wondered how he felt about being sent. He replied that he had been very mad about going there, although later he had seen it as a good experience. I commented that he could be equally mad about being here to consider return. While Mr. Donovan digested this, I told him of what we could now offer which might make the experience more constructive. I would be working with his mother, while he was away, to help her see his need to grow to be a man. I would be here to help him with employment and family problems on his next return to the city. Mr. Donovan's face lighted up and I felt some genuineness in his positive response. He thinks now he can use the Rehabilitation Center more constructively on his second try and maybe he will do better when he is next out again. I recognized here that I knew he had a choice between the Rehabilitation Center and prison and under the circumstances he might well feel he had to be pleased about his return. Mr. Donovan agreed, and then went on to express conviction that my being here will be a help to

him. Shortly thereafter, he left my office. I felt that this excessively dependent person would not have been helped by being forced, as many authorities had already tried, to accept full responsibility for all his misdemeanors. All I had asked of him was recognition of his feelings around the authoritative act. This apparently had a wholesome effect, judging by letters to his mother after he had returned to the Rehabilitation Center and by his eagerness to connect with the clinic as soon as his second discharge was effected.

In such a patient who comes in under police duress, after spending some time in a jail or prison, an experience which has crystallized or intensified his hostility, the dynamic behind the apparent friendliness and superficial docility are often easy to see. The childish rebelliousness and vengefulness and the need for eventual expression of this in conspiracy with other patients are particularly important to cope with at the point of intake, since this is the kind of patient who will more than likely begin his state supervised alcoholic treatment in an inpatient facility.[6] This point of intake, which may at the same time be the point of evaluation for referral, is the ideal point to break into this cycle, not only for the benefit of further treatment, but for clearing away enough emotional ground at the moment so that the patient will be able to move to ground relatively free of the distorted rage reactions he is harboring toward authority in general. I think this can and must be done even when history taking or other screening activities must also be involved. I recall one patient who came to me in this fashion for screening: he told me of his many years as a merchant seaman, of his interests and hobbies and of the loneliness which he felt led him to drinking. He so readily took upon himself the blame for his many arrests and spoke so positively of his interest in rehabilitation that I was lulled into abandoning a full exploration of how he came to jail and how he felt about it. Interestingly enough, he continued this docile pattern for about a month at our Rehabilitation Center and then suddenly anguish for his mother and rebellion against the Center (expressed in a drinking spree) changed our whole knowledge of this situation and revealed how inadequate the screening had been because of my failure to cut through to his feelings about his mother and her role.

It seems to me that working with the alcoholic places an especially great strain on the emotional resources of the worker—more so than the neurotic who by and large shoulders the anxiety and the responsibility for himself, or the psychotic, who has thrown it off completely. The alcoholic has, to dramatic effect, involved his family and his environment in acting out his immaturity and rebellion—he has forced those around him into sterotypes or caricatures of the complex real people they are—and suddenly, you, too, are in the middle of this vivid drama with him. In such a situation, the pull to unconscious identification with the patient and rejection of the authority figure is powerful and requires that we be constantly on guard for our own reactions in such case situations. I recall Mrs. Howard, who came to me first to talk about her husband. They owned a small grocery store together and his rifling of the cash drawer for liquor money was only the beginning of her complaints. Apparently, he became really fierce under the influence of alcohol, tore up their household furniture, beat her and stripped her of her clothes, etcetera. Mrs. Howard was a woman of generously Juno-esque stature whose hostility toward the entire male sex and vengefulness for them were painfully apparent. On a later day, Mr. Howard came in. He was a small man, gentle, pleasant and attractive. After he had left my office, in fact, when I was later wondering why he had failed to return, I noted that I had failed to make any attempt to cut through to his feelings about being coerced into our clinic. I began to wonder why I had not done such an obvious thing—certainly I had seen the wife's role clearly enough to sense the importance of dealing with this. Later, I saw that my own never completely resolved resentment toward authoritative figures, a resentment everyone develops in the course of growing up, must have been so stirred that when I failed to face myself honestly with this phenomenon, too much of my interview energy or emotional energy had been expended in keeping my own feelings under tightly bound control. Thus I had fallen into one of the basic traps of social work—too complete indentification with the patient. I saw that my failure to deal with my own hostility toward this overbearing spouse rendered me quite impotent in dealing with the same feelings in the patient. And yet, as mature workers, we can recognize easily in the abstract that these enveloping and overwhelming people were just as trapped in this miserable constellation of authority and rebellion, excess love and excess hate, as the alcoholic himself. I do not think there is any specific technique to prevent this type of response toward some of our patients' families arising in ourselves. Perhaps we can, however, by frankly recognizing

how such persons tend to throw us back to our own childhood constellation of immaturity and dependency, have the self-awareness to cope with our own feelings consciously first. Then we can move on, in more orderly fashion, to help the patient with his thousand-times more violent response to the same stimulus. Perhaps another way of saying this is to say that when our alcoholic comes in to us under duress, we do not need just to get the feel of the individual. We need, more than in most intake, to assess the constellation of emotional forces involving patient and family, and then, with full self-knowledge, we need to make sure that we have not unconsciously made ourselves a part of it. Rather, our role is to cut through this constellation enough so that some of the patients' emotional energy hitherto involved in holding this little cosmos together will be diverted to making a first tiny and tentative step in a new path or pattern. The patient must know that we accept him, as a person, almost as an act of faith on our part, rather than the him he now accepts himself, caught in a pattern of seemingly never-solved rebellion.

Give the Patient a Chance to Say "No"

Another professional prerequisite for all first interviews is that we must help the patient test out whether or not he really likes the idea of coming to this kind of clinic and really wants to get help for his alcoholism. For me, this has proved of special difficulty in an alcoholic clinic for three reasons. First, with the alcohol clinic's high mortality rate with patients I find it takes more courage on my part to offer the patient an opportunity to say "no" than it does elsewhere. Second, with the family or social agency breathing hard in the waiting room it becomes more difficult than ever, although at the same time, the freedom to do this means more to the alcoholic. Finally, I have found that in almost every other social agency you, the worker, are bolstered and supported by a great deal of tradition and background as to what to do with the patient, even if you do not refer him on to another therapist or another service. Here, because what we offer is more flexible, more depends upon you, the individual worker. Thus, we are asking the patient to test out with us something that we have much more ego-involvement with than in old-line agencies. Testing out with you what the clinic has to offer is testing you out—or so you are often likely to feel. Again, clear acceptance of this is the only way to be comfortable. Of course, the patient is not really testing *you* but only testing whether through you he can gain the courage to come to grips with himself. Here we as workers cannot afford to deny our feelings—we must acknowledge to ourselves our own threats and insecurities, watch them for the ever potential threat that they present to us in our relationship to the patient. Then we must go over and beyond ourselves to an honest search for and recognition of what is the seedling of strength in this immature and indequate person, our patient. In my limited experience, I have found this marked inadequacy on the part of the alcoholic to be a real underground source of disturbance to me, probably because it stirs unrecognized fears of one's own inadequacies—particularly when it looks as though we will never succeed in building a full caseload for our clinic! Here, too, it occurs to me that recognition of this is a goodly part of handling it. Woe to those of us who project our own inadequacies onto our already overburdened clients!

To summarize, I have tried to approach the problem of intake technique with patients who come to the alcoholic clinic under duress in two ways: I have tried to isolate the critical relationship factor operating between the alcoholic and the authority figure at the moment he comes to us, and to suggest that it is imperative that we recognize the elements of hostility in this and, if at all possible, help the patient to verbalize. Beyond this, I have tried to suggest that the alcoholic stirs up many unconscious responses in the worker which must be recognized by the worker so that they do not interfere with the hoped-for two-way relationship. As Dorothy Baldwin says: "The caseworker must bring up from the sea of unconscious a half-drowned wish for normal living and normal satisfactions and apply to it the artificial respiration of her most subtle and unwearing techniques."[7] With the addition, I might add, of continuous and wearying recognition of herself as the agent, through which this near-miracle must come about!

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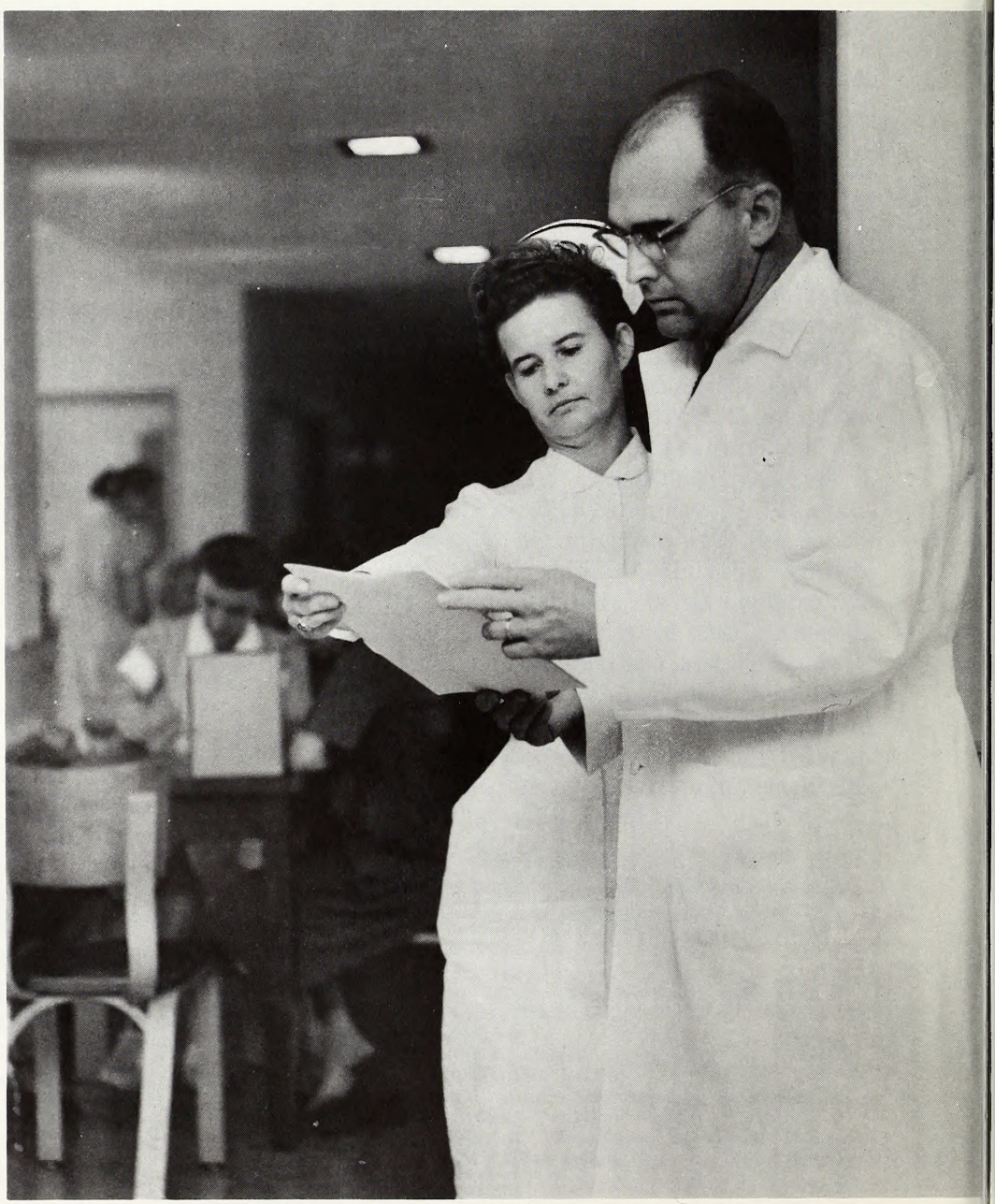
NOTES

An Ongoing Alcoholism



BY BETTY B. NELSON, A.C.S.W.

Program in a State Mental Hospital

The development of an alcoholism program at the Eastern Shore State Hospital was a process which began nearly a year before the formal establishment of a separate unit and program for alcoholics. The need for some different approach to the alcoholic, who accounted for nearly 40% of male admissions, was felt by the administration and staff members who were responsible for the care and treatment of these patients. When sober, the alcoholic usually reclaimed his difference from other patients with whom he found himself and persisted in denying his need for any help the hospital could offer beyond "drying out." Over the years various attempts had been made to design a program. Usually this consisted of some type of group therapy. Beginning in 1961 a group was formed which continued during the period of the development of a special program for alcoholics. The next step in the development of the program was the selection of interested staff, beginning with a male nurse who would be in charge of the unit. This person was sent to the Yale (now Rutgers) Center of Alcohol Studies. After his return, staff from other disciplines were selected on the basis of their experience and desire to work with alcoholics. A working plan was drawn up by this group and the Alcoholic Rehabilitation Unit was opened on March 21, 1962. Perhaps the date had some special significance to the hopeful people—staff and patients—who were involved in this. It is the first day of Spring.

The staff was ready to begin the carefully designed program with full awareness that there would be many modifications of "the plan," but with the basic conviction that the very existence of the unit carried the implicit recognition that the alcoholic could be helped. Here was a place for him. This climate of acceptance is an important factor in the treatment of the alcoholic whose life experience usually is repeated encounters with rejection, including his own self-rejection. Experience with the program has indicated, too, that a special unit for the alcoholic lessens his tendency toward denial for he is daily confronted with the reality of the setting in which he is being treated. He sees himself reflected in the newly admitted patient, often suffering physically and intoxicated, and can also turn the mirror to the man who has some sobriety behind him in the hospital and is on his way out. Often during his stay, a man will see others who have had many admissions to the hospital, and may be impressed with the seriousness of alcoholism. The group provide for each other an "education" that no staff person could ever give them.

Patients are admitted to the Alcoholic Rehabilitation Unit on voluntary, court, and medical commitments. There seems to be little connection between the kind of admission and the motivation of the patient. Few "voluntary" admissions are entirely voluntary. The choice is not fully made when a patient signs a voluntary commitment. He must reaffirm this choice when he knows more fully what he has gotten himself into. In the original planning for the unit, six to eight weeks was considered the "ideal" time for a patient to remain in the hospital. This has been modified in practice and most patients are staying two to four weeks. One of the most challenging problems has been how to help a man remain in

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the hospital until he has a long enough experience of being sober to move confidently to the next step he must take, or to phrase this in the language of the alcoholic, until he has begun to "think sober." Usually the return to reality is quick for the alcoholic because of the acute nature of the reaction (despite its chronic pattern) and as impulsively as he has sought help, he will reject it. The prospect of facing himself and his problems is painful and he will want to move on, usually with some magical idea of how he can make up the time, money, etc., he has lost while drinking. Some significant aspects of what determines how long the patient will stay—or more truly, whether he can yield or surrender to his need for help—seem to be the climate of group attitude on the unit at the moment, the expectations of the staff, and how they communicate these, and, of course, outside factors of family, job, etc.

Involving the Family

The family of the alcoholic needs to be involved for they, too, often have unrealistic expectations of treatment, revealed by such naive suggestions as the patient should stay in the hospital until he is "cured." Having endured too much too long in many cases they are reluctant to accept the patient, do not expect him to change, and see no part they can play in his recovery. The social history interview—a part of the admission service for all hospital patients—is used to explore family attitudes and to help the family gain some understanding of alcoholism as a progressive illness, long in developing and long in recovery, with hospitalization a first step. Patients are encouraged to try weekend or short visits at home to test out some of the gains they may have made in the hospital. This provides an opportunity for the patient to see if he can maintain his sobriety for a limited period in a setting more threatening to him than the hospital and also an opportunity for him and those with whom he lives to begin to restore some of the damage in relationship that preceded admission to the hospital. Even when the family has been most supportive of the alcoholic, particularly in his desire to seek help, there is great uncertainty about how it will be when he returns home. They need some time to accept the idea that even sobriety has its problems. One wife complained that her husband read for hours at a time when he first came home.

From the beginning of his hospitalization, the patient is encouraged to take as much responsibility for himself as is appropriate. The approach is to give him—in small ways at first—control of his own life, which he had given up to alcohol. This responsibility is carried by the group as well as the individual. A man is put to bed if he is intoxicated or physically ill at the time of admission. He is given the necessary medical and nursing care. Other patients on the unit are expected —and willingly respond—to help care for a new admission. Some are assigned to "sick bay" duty and will sit with a new patient, seeing that he does not get up and wander, assisting him to the bathroom, taking liquids to him as ordered, and bringing his meals. All ward cleaning is done by the patient group. Each is responsible for his own sleeping area—the ward design consists of a number of three and four bed rooms and a day room—and some part of the bathrooms and general areas. The charge nurse encourages and stimulates the group to make the unit the kind of place in which they want to live and can show with some pride to visitors and others. Morale showed a real slump during a time when the unit hall was a thoroughfare for patients from another part of the hospital. The alcoholics sounded like the frustrated housewife who just can't "keep the place clean!" Cries of "What's the use, they just mess it up," and the like were heard and were used by staff to point up to the alcoholics what these comments reflected about their own personalities.

In addition to their responsibility for cleaning their own living area, all who are physically able are placed on industriay therapy assignments. In the original planning for the unit, it was thought desirable to have a group work-project for the alcoholics. Hopefully, this would be a task that could be completed with a sense of accomplishment in some limited period of time. Such a task did not materialize and the patients were assigned on an individual basis. This seemed more realistic in some ways for rarely in the community would the alcoholic be working in such a group. More recently the dilemma of group assignment versus individual assignment has been resolved by having several alcoholic patients assigned to industrial therapy in a particular area, usually dining rooms and the geriatrics building. This seems preferable for they are not entirely separated as a group during their working day, but are working with others on assignments where their contribution is valued. Work assignments are considered an important part of the therapy with alcoholics. Most of them have useful skills and can do a good job. In the community they rarely lose jobs because they can't do the work. However, the

alcoholic is often prone to substitute work for drinking and is as compulsive about his job as he is about drinking, working long hours, taking on extra jobs, and pushing himself beyond his capacity to keep up. This almost inevitably leads to drinking again. The wisdom of the A.A. slogan—"Take it Easy"—is apparent here. This tendency to overdo often comes up in the hospital and gives staff an opportunity to explore this with the patient in a helpful way. Group discussions can start around what to do about the patient who says he can't go home for the weekend because there would be no one to wash the dishes or the group of patients who complain that the time of the doctor's rounds interfered with their work detail and maybe they couldn't see the doctor. A.A. has a word for this, too, "First Things First," but the alcoholic needs help in discovering what is first at the moment.

The Alcoholism Program

In addition to industrial therapy, the alcoholism program includes weekly group therapy sessions, a weekly group meeting with the chaplain, and A.A. meetings. The social worker sees families and patients, particularly in relation to the release planning. Again the focus is on helping the patient increase his confidence in his ability to solve his own problems, using his own resources. It has been the social worker who has been most active in extending and interpreting the program in the community.

The chaplain's group was added to the program several months after it began. The need for this came out of the group therapy sessions and informal discussions with the alcoholics. They seemed to be expressing many spiritual or religious concerns, often without recognizing them as such or knowing that religious understanding might provide some answers. They had many distorted ideas about sin, themselves as sinners, and any possible hope of redemption. Most had long since separated from the church but remembered somewhat negatively earlier experiences with religion. It was felt that the chaplain's group would meet the religious needs of the alcoholic in helping him to believe, if he could, that God cared about him. From this group, some found their way to the more formal religious services in the hospital and to a different relationship to the church in the community.

Alcoholics from the hospital had always been invited to the A.A. group in the community if they wanted to attend. Transportation was provided by A.A. members, but attendance had fluctuated for there was no continuity of responsibility of hospital personnel to encourage the alcoholics to go. Shortly after the opening of the Alcoholic Rehabilitation Unit, a closer working relationship with A.A. was developed and a hospital group was started, sponsored by the Cambridge Group. Since patients come to the Eastern Shore State Hospital from eight surrounding counties, A.A. members from groups in this area were encouraged to participate in the hospital group. In this way, the patients might make some beginning connection with the group nearest them before leaving the hospital. They were still able to attend the Cambridge Group, so there were two A.A. meetings a week available. The staff placed a strong expectation on the patients to attend these meetings. For those to whom A.A. was unknown, attendance was required at least once. It is important to say that strengthening of a working relationship with A.A. is a developing process which needs continual nurture. For they, too, feel and perhaps reflect the disappointments and frustrations that the unit staff experiences from time to time. They need reassurance that their efforts and contribution to the program are valued. From time to time A.A. members have been invited to meet with the Alcoholic Rehabilitation unit team to discuss better ways of using all our resources. The staff is eager to have more A.A. members visiting on the unit, making individual contacts with patients whose prospects for recovery seem hopeful. Some former patients, with a year or more of sobriety out of the hospital, have been helpful in establishing this kind of relationship with patients. One of the real rewards for staff and encouragement to the alcoholics is a visit from a former patient who can say "I'm making it." Many come back to say this.

In addition to these structured group sessions, many informal group discussion or "bull sessions" take place on the unit. Often these follow a formal group. The nursing personnel are alert and aware of the composition of these sub-groups and can contribute in staff discussions which patients spend their time together. These observations can contribute greatly to understanding and evaluating a patient's progress. The nurse's office is open to patients who want to talk and nursing personnel on this unit know their patients well. The charge nurse encourages attendants on other shifts to discuss with him their impressions and observations beyond what goes in the formal "report." Each member of the team feels he has a contribution to make.

Court commitments include voluntary petitions

from equity courts as well as commitments under the Maryland law for treatment of alcoholism following a criminal conviction (usually for a minor crime). Often patients committed by an Equity Court have been arrested and hospitalization suggested to them or to the court by a police officer as more appropriate than a short jail term. Interpretation of the hospital treatment program to the courts involved has been done sometimes by a general discussion with a State's Attorney and sometimes around a specific case with the judge and others. Some patients have been committed for treatment as a condition of probation. In these cases, the probation officer has been invited to the hospital to participate in staff conferences about the patient. This has increased community understanding and acceptance of the program in most instances. Courts and legal agencies have been found flexible when they are involved. The judge who "sentences" a man to the hospital for sixty or ninety days will understand the rationale of weekend visits, earlier release when recommended, and will appreciate the therapeutic risk involved in what may seem at first like too much freedom or too lenient a policy.

Like all treatment facilities for alcoholics, the state hospital is not immune to the problem of patients' drinking during hospitalization. Alcoholics are notoriously clever in devising ways to secure alcohol and to expect them to abandon the effort completely when in a hospital would be naive. The healthiest deterrent to drinking in the hospital is, of course, the disapproval of the group and staff disapproval, expressed without rejection of the person. Group disapproval is not always a reliable deterrent for if the current group is made up largely of alcoholics with little motivation for help, they will not identify with staff and will be quickly contaminated by the drinking members. However, if group morale is high, they will demand that something be done about the man who is drinking. Something must be done in either case. There are administrative considerations, obviously, and also important dynamic and therapeutic reasons for responding quickly and positively to any drinking on the unit.

Earlier in this paper, family involvement was considered. In a state hospital setting, many alcoholic patients are long-time, chronic drinkers whose family ties have long been severed. These are lone men who may have had many hospitalizations and frequent jail sentences for drinking. They do not fit most appropriately into a short-term, intensive rehabilitation program. In an effort to meet some of their needs, a "night hospital" phase has been added to the program. If these men go out with no money or other resources, they will almost inevitably begin drinking again, probably within hours after they are released. In an effort to give them some experience of what it can be like to be sober, working and earning, they are permitted to go into the community after the second or third week of hospitalization to look for employment. If they get a job, they may begin working, returning to the hospital at night for another two or three week period until they have earned enough to move out into the community. During the time they are on night-hospital status, they understand they are still patients, are expected to attend A.A. meetings and see the social worker or doctor on the evening they are available to discuss the progress of their job and plans for leaving. Nursing staff, of course, has daily contact with these patients.

The Hospital Program Is Only a Beginning

After a few weeks in the hospital treatment program the patient is released. Treatment of the alcoholic is a long-term process and this has only been the beginning. Hopefully, he has developed some inner strengths and resolve that will sustain him in his struggle for sobriety, but the need for some sustained after-care is apparent. It is difficult for the alcoholic to form meaningful relationships. In the hospital he has had the opportunity to develop relationships with staff members who are the strong personalities he needs. He may have made a meaningful connection with A.A. which will be there for him when he leaves. To provide an aftercare resource for those who could use it, an evening clinic was established about one year after the opening of the unit. The psychiatrist and the psychiatric social worker serve this clinic which is at the hospital. Use of it is limited for many patients who may live sixty or more miles from the hospital. However, many in the immediate vicinity of the hospital do use it and some have come as far as thirty or more miles. A number of wives have come from time to time with their husbands. One former patient was permitted to come from the local jail each week where he was serving time for being drunk and disorderly.

The alcoholism program at the Eastern Shore State Hospital is still evolving and developing. It is in this sense truly an "ongoing" program. Hopefully, it will not lose this dynamic quality for in helping alcoholics one learns to live unto this day and meet the needs thereof.

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